

MILITARY CHAPLAINS'

REVIEW

1976

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DEATH AND DYING



SPRING, 1976

PREFACE

The *Military Chaplains' Review* is designed as a medium in which those interested in the military chaplaincy can share with chaplains the product of their experience and research. We welcome articles which are directly concerned with supporting and strengthening chaplains professionally. Preference will be given to those articles having lasting value as reference material.

The *Military Chaplains' Review* is published quarterly. The opinions reflected in each article are those of the author and do not necessarily reflect the view of the Chief of Chaplains or the Department of Army.

Articles should be submitted in duplicate, double spaced, to the Editor, Military Chaplains' Review, United States Army Chaplain Board, Fort Wadsworth, Staten Island, New York 10305. Articles should be approximately 8 to 18 pages in length and, when appropriate, should be carefully footnoted.

EDITOR

Chaplain (LTC) John J. Hoogland May 1971–June 1974

Chaplain (LTC) Joseph E. Galle III July 1974–

A MATTER OF LIFE AND DEATH

Considerable literature has been published on the subject of death. Thanatology courses attract large numbers of high school and college students as do conferences and symposiums attract others. Television has highlighted the subject over major networks. All would indicate that there has been a growing interest in recent years to talk openly about death and dying.

Despite the increasing interest, however, there remains a significant number who seldom reflect on death. To some, perhaps many, death seems so far in the future that it is irrelevant to current living. As one of the authors for this issue of the *Review* puts it, "Our daily attitudes and actions are more consistent with the conviction that personal death is an unfounded rumor."

Though we have no control—no choice—over our eventual death, we are not left to wait helplessly for it to come. We may choose our attitude toward death and how we will live the balance of our days, weeks, months, or years. Henri Nouwen of Yale suggests, "Let's so live that when we die, we'll become what we've given."

Marjorie McCoy, author of *To Die With Style* reputation, explains that we die the way we live—"We achieve our death," she writes, "throughout our living." We are right now the persons we're aiming at becoming; and we all become ultimately what we aim at.

Those whose articles appear in this issue of the *Review* demonstrate profound perception as they share their extensive research with us or permit us to share their most intimate experiences with death. All, however, remind us that *dying is a matter of life* as well as death.

The two are inexorably bound together. If we deny one, we deny the other. When, however, we accept both with some degree of understanding, we can live fuller lives and experience more dignified deaths.

ORRIS E. KELLY

Chaplain (Major General), USA
Chief of Chaplains

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, D.C., *Spring* 1976

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“Our daily attitudes and actions are more consistent with the conviction that personal death is an unfounded rumor.”

—Earl Grollman

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“I think the most valuable gift we can give to each other is acceptance; especially to the dying person who has no experience on which to rely. He has never died before and so his coping mechanisms might not always be acceptable.”

—Joy Ufema

* * * * *

“Our concept of dignity contains the elements of self-respect, poise, impressiveness of character or manner, repose and serenity of demeanor.”

“In the past people were afraid they would die if they went to a hospital. Now they are afraid they will not be allowed to die.”

—Jai Swyter

* * * * *

“My only qualification (about publishing these notes) is that I am dying, and that is really not unique. You are dying, too.”

—Richard Johnson

* * * * *

“Our son, Ken, died suddenly one night. We were totally unprepared for his death.”

—David Coulter

DIGNIFIED DEATH: AN IDEAL

Jai Swyter

INTRODUCTION

Speaking at a conference on ethics and theology, Margaret Mead said, "If we want a society in which older people, acting with the dignity of an Eskimo grandmother, decide they will no longer be a burden on the young, then that must be the decision of individual human beings. Society itself must back up such individual decisions" (Mead, 1970). The Eskimos choose to die in a manner which, according to our laws and dominant values, is suicide and forbidden. And yet, there is a growing number of individuals who feel the Eskimo custom is dignified and desirable. This new perspective is evidenced by the increase in discussions of such formerly taboo subjects as euthanasia, death and dying, death with dignity and the right to die. Television, newspapers, books, conferences and legislation are beginning to reflect this new awareness.

Our concept of dignity contains the elements of self-respect, poise, impressiveness of character or manner, repose and serenity of demeanor. It is recognition, by ourselves and others, of the inner strength to live up to our personal ideal of how and what we want to be and do. It is the ability to recognize the reality of our world and to act accordingly. It is the courage to see and to do. It is from this position that we see the Eskimo custom as dignified.

This paper will be an inquiry into why the Eskimo custom is seen as our ideal of a dignified death. Eskimo and American practices will be reviewed including influential environmental factors. Comparing dying in these seeming vastly different cultures will help define and clarify what a dignified death means to us.

DYING IN THE ESKIMO SOCIETY

Aged Eskimos are treated with great respect but are put out of the way when "life becomes too heavy for them." The act is usually done in accordance with the wish of the person concerned and is thought to be a proof of devotion. The Eskimo belief system also affords special compensation for someone who dies a violent death for he will be transported to the highest heaven. Suicide is not a rare occurrence

The author has worked as a research dietitian on kidney dialysis and transplant units in San Francisco, Baltimore, and Washington, D.C. This work led to a new professional interest in chronically ill and dying people. She is currently working on a Ph.D. in medical anthropology for use in clinical work, teaching, and research in ethical dilemmas in which death is one of the choices.

and is usually brought about by hanging (Boas, 1964; Simmons, 1945). Freuchen (1961) vividly describes this custom:

Life is their essential concern. The thought of death is remote. But suicides are numerous among them. If they are hit with sickness, if great human sorrows weigh them down, when—as they express it—“life is heavier than death,” then no man hesitates to make an end of his torment and cross into the distant land. In many places, voluntary death is normal for old men and women who are burdened with the memories of their youth, and who can no longer meet the demands of their own reputation. Old people kill themselves to avoid being a hindrance to their kin.

Fear of death is unknown to them, they know only love of life. The Eskimos are themselves unaware of the difficulty of their existence, they always enjoy life with an enviable intensity, and they believe themselves to be the happiest people on earth living in the most beautiful country there is. When an old man sees the young men go out hunting and cannot himself go along, he is sorry. When he has to ask other people for skins for his clothing, when he cannot ever again be the one to invite neighbors to eat his game, life is of no value to him. Rheumatism and other ills may plague him, and he wants to die. This has been done in different ways in different tribes, but everywhere it is held that if a man feels himself to be a nuisance, his love for his kin, coupled with the sorrow of not being able to take part in the things which are worthwhile, impels him to die.

In some tribes, an old man wants his oldest son or favorite daughter to be the one to put the string around his neck and hoist him to his death. This was always done at the height of a party where good things were being eaten, where everyone—including the one who was about to die—felt happy and gay, and which would end with the angakok conjuring and dancing to chase out the evil spirits. At the end of his performance, he would give a special rope made of seal and walrus skin to the “executioner,” who then placed it over the beam of the roof of the house and fastened it around the neck of the old man. Then the two rubbed noses, and the young man pulled the rope. Everyone in the house either helped or sat on the end of the rope so as to have the honor of bringing the old suffering one to the Happy Hunting Grounds where there would always be light and plenty of game of all kinds. There a man can decide whether he wants to go bear hunting, caribou hunting, or fight the walrus in a kayak.

Old women may sometimes prefer to be stabbed with a dagger into the heart—a thing which is also done by a son or a daughter or whoever is available for the deed. There is absolutely no cruelty connected with this. They just believe that life has come to an end. The many suicides and murders among the primitive Eskimos must be seen in the light of this intimacy with death.

The Eskimos demonstrate an extreme example of adaptation to a harsh environment. They are faced with the objective geographic realities of long, cold winters, lack of timber and often unpredictable game concentrations. Their subsistence techniques, economic organization and settlement patterns are evidence of the ecological adaptation to the environment. Food is often in short supply and hard to procure leading to yearly migrations based on availability of game.

With these migrations group structures constantly change from single family to multi-family units. Sharing of food is highly valued and various sharing patterns equalize food distribution within the community and over time.

The continuous pressures and hardships necessitate internal sociodemographic controls. Rigorous female infanticide is practiced as is suicide in crisis situations, invalidicide and senilicide. These are adaptive responses to harsh pressures and eliminate unproductive members. In this way family size is adjusted to the capacity of the provider and survival chances maximized (Balikci, 1968).

DYING IN THE UNITED STATES

In American society the dying role is severely attenuated and death seen as a technical failure. The prospect of death does not fit well with the dominant values of youth, future-orientation, doing and mastering over nature. The dying person is frequently defined as "irresponsible" and his consciousness, self-control and decision-making are taken away. Changing technology has also enlarged the dying process to a median of 29 months between the onset of illness and death (Levine and Scotch, 1970). 60.9 percent of all deaths in this country occurs in institutions (e.g., hospitals, convalescent and nursing homes) partly as a result of science and technology having changed the leading causes of death from the major communicable diseases to chronic degenerative illnesses (Lerner, 1970).

Western society dichotomizes and depersonalizes death. Except for accidental death, where and when a person dies tends to be determined by who has control over his life at the time. The person who maintains awareness and social control may have some choice but the unaware and debilitated do not (Knutson, 1970). Estimates of "social worth" are placed on a person's life by his culture. There is a relationship between dying and age, race, occupation, attractiveness of the patient and his disease, religion, political affiliation, sex, ability to pay, relationships with the patient's relatives and the individual's place on the optimism-pessimism continuum of a particular disease (Lasagna, 1970).

This American way of dying is described in the case history of "Mrs. Abel." During the four months of this woman's lingering, painful, dying trajectory in a hospital, all human relationships became attenuated or collapsed completely. Surgery, with the implicit hope of death and relief, was only the last event in the drama of her gradual, if not entirely total, insulation from personal and professional relationships with the staff (Strauss and Glaser, 1970).

These observations are corroborated in an ethnographic study of death and dying in a county hospital setting. When a person is considered to be "dying" varies according to his location in a variety of social structures such as family, hospital, occupationally structured careers of the society and the age-graded system in general. "Dying" is essentially a predictive term and is clearly distinguished from disease categories and bio-chemico-physical status and processes. Social death frequently occurs prior to clinical death (i.e., "death signs" on physical exams) and biological death (i.e., cessation of cellular activity). Social death is that point at which the socially relevant attributes of the patient begin permanently to cease to be operative as conditions for treating him, and when he is essentially regarded as already dead.

A common example of the set of practices known as social death involves the assignment of patients to beds. A patient who is admitted to the hospital in what is considered a near-death state is frequently left on the stretcher on which he is admitted so as not to "mess up a bed." If he is still alive in the morning he is assigned to a bed and treated as a person instead of a corpse. A so-called "comatose" patient is treated as essentially dead. Such an assessment is made when the patient does not respond to verbal or physical stimuli. That the nonresponsiveness may be an inability to respond to, rather than receive, stimulation is not seriously entertained. A noncomatose patient who is expected to die on the current hospital admission cannot be the object of predeath treatment as a corpse until the coma itself is entered. In such a patient's presence talk about his prospects is camouflaged by use of descriptive language supposedly unintelligible to the patient. Such social arrangements as heavy sedation and social death bring about a "vegetable life" rather than allow the death of a live person (Sudnow, 1967).

Dying is a status passage between life and death that is, unlike other status passages (e.g., marriage, birth), non-scheduled, non-prescribed, undesirable and, past a point, inevitable. The physician legitimates this passage and defines its temporal dimensions by deciding how much to tell and when. His professional rule is not to tell, thus, denying time for completing unfinished business (Glaser and Strauss, July 1965, 1968). Hospital patients frequently do not recognize their impending death even though the staff does. This "closed awareness context" is determined by four structural conditions:

1. Most patients are not especially experienced at recognizing the signs of impending death.
2. Hospitals are magnificently organized, both by accident and

design, for hiding the medical truth from the patient (e.g., records are out of reach, staff acts collusively and is skilled at avoiding conversation, medical talk about the patient occurs elsewhere).

3. The physician is supported in withholding information by professional rationales (e.g., why take away all hope by telling a patient he or she is dying).
4. The patient has no allies who can help him discover the staff's secret—even family members or other patients withhold information if they know.

In addition, staff members utilize a number of "situation-as-normal" tactics to prevent the patient's comprehension such as reassurance, carefully controlled facial expressions and reduction in the time spent with him (Glaser and Strauss, 1964, 1965).

And finally, the consent of the patient or his agent is only one factor influencing the physician's decision to treat or withdraw treatment. The dimensions of the prognosis (salvageable to unsalvageable) and type of deficit (physical and/or mental) are of primary importance. Within this framework a patient who wants active treatment is likely to get it. Withdrawal of treatment depends less on consent than on the physician's assessment of the patient's prognosis and type of deficit. A patient with a severe physical deficit whose condition can be maintained for a considerable time is likely to be actively treated against his wishes or those of his agent (Crane, 1973).

As with the Eskimo, these practices represent an adaptation to our environment of science and technology, deritualization of mourning and grief, growing impersonality, decline of kinship ties and increasing social fragmentation (Feifel, 1969). Subjectively it can be as harsh and unrelenting as the objective geographic environment of the Eskimo.

THE IDEAL: A DIGNIFIED DEATH

With the rise of humanitarianism in Western culture two aspects of medical ethics governing ideal medical behavior have begun to contradict themselves. The first is the sanctity of human life which stems from a belief that man's survival is part of God's design. The second is the ethic of humanitarianism which prescribes alleviation and prevention of suffering (Brim, 1970). Added to this is a growing acceptance of passive euthanasia among both physicians and laymen. This is linked to the greater representation of the elderly in our population and, with the consequent rise in incidence of incurable disease, the increasing willingness of society to confront death and its prob-

lems and, above all, to the wizardry of modern medicine in sustaining life in debilitated patients who, years ago, would have died quickly, quietly and inexpensively. In the past people were afraid they would die if they went to a hospital. Now they are afraid they will not be allowed to die (*Medical World News*, 1973).

As in life, man's fate is determined by the morés of his time and place and ranges from the heights of homage to the depths of degradation. In our future world man will die either because he wants to or someone else decides it is time for him to die (Brim, 1970). Most of us will be faced with asking when is death an acceptable event in my life and what are the appropriate conditions of my death (*Geriatrics*, 1972). Significant survival and significant death mean that we are freed from the tyranny of suffering, impoverishment, disenfranchisement, and gross incapacity. The only consolation that authentically can be offered to a person facing imminent extinction is the freedom to die his own death. The freedom to die is the only option consistent with being able to live responsibly our own life. The pervasive dread in dying seems not only to be the extinction of consciousness, but the fear that the death we die will not be our own. This is the singular distinction between death as a property of life and being put to death (Weisman, 1972).

The American way of dying is a creation of our environment but not a positive adaptation to it for it negates authenticity and self-respect by being negatively defined and controlled by others. The Eskimo custom of choosing death when life weighs too heavily acknowledges and respects the courage to recognize the reality of one's world and to act in accordance with that reality. To Americans who value action and mastery over nature, the Eskimo custom seems the ideal for it allows some control over the fact and act of dying. To individuals who value consciousness, warm human ties, personal dignity and freedom, the Eskimo way of dying assures a significant death at an acceptable time and in an appropriate manner. Because the Eskimo custom and culture are integral, no irrational guilt feelings are aroused and self-respect and unity are maintained.

By dying honorably, courageously, even heroically, people of primitive societies have had a final opportunity to inspire respect and admiration. This gaining of sympathy and prestige is dependent on a combination of necessity and the willingness on the part of the old to die courageously when circumstances require it. Environmental conditions should make it necessary. Cultural beliefs about life, death, gods and the hereafter should inspire the deed and cushion the blow. Established precedent should prescribe the manner of dying. Friends, and possibly a celebration should attend the ceremony. Finally, the aged person should demonstrate sufficient force of charac-

ter to meet the hard challenge courageously and the act should not be put off too long for the very senile who have lost their courage or returned to childish ways and will not be able to play their proper part (Simmons, 1945).

Members of modern society are also asking for this final opportunity to inspire respect and admiration by dying honorably and courageously. Rather than naively suggest a return to the past we see the Eskimo way as an ideal of how we can solve some of our moral and ethical problems surrounding prolongation of life and a dignified death. The "dignity of an Eskimo grandmother" means the courage to see when one's life has become a burden to one's self and others, the self-respect to act on that reality and choose to die, and the affirmation of that action by friends and society. It is in this dignity and courage that we see our ideal.

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“I LISTEN; I LOVE; I LEARN”

Joy K. Ufema

There is an ancient Persian legend that tells of the servant who burst into his master's quarters pleading for a fast horse to flee to Samarra. He exclaimed he had just met Death while walking in the marketplace in Bagdad. The master granted the servant's request but a bit later while walking in the marketplace met Death sitting near a tree. “Why did you frighten my servant?” inquired the master. And Death replied, “I did not wish to frighten him. I was just a bit startled to see him here for I had an appointment with him in Samarra later tonight.”¹

Like the Persian servant we all fear death. We many times delude ourselves into thinking that ignoring it will make it “go away.” Death's inevitability makes this means of coping inadequate. It is difficult today not to be exposed to death and its ramifications, let alone actually to experience it. Various media bombard our homes with numbers and pictures of nameless bodies killed either in war, revolution, or accidents. We can always turn the channel to something more comforting or choose to read the comics instead of the front page of the newspaper, but we never really escape the grim reminders of our mortality.

I have chosen a different way of coping. For the past three years I have been working exclusively with dying patients at Harrisburg Hospital in Pennsylvania. I am a nurse specialist in death and dying. Though I find the work difficult at times, it is quite rewarding. While doing general duty I was caught up with many obligations to patients, none of which included time with the dying person or his family. I requested to be relieved of my evening charge nurse responsibilities and to be given a newly-created position—death and dying. Throughout my nursing education I sought out special workshops and seminars teaching thanatology. I read and studied all available literature on how best to help the dying person. I then adapted this information to deal specifically with the dying person as a patient. It is to this theme that I direct this article.

While riding the elevator one morning, I was confronted by one of the physicians who mentioned that he hadn't seen me on the Urology Department lately. I explained about the change and briefly de-

¹ W. Somerset Maugham, the play “Sheppey” (New York: Doubleday and Company, Inc., 1934).

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scribed my new work. "Death and Dying!" he blurted out, anxious to get off the elevator, "I got a guy for you—Fitzgerald on M-4!" (Thus came about my first referral.)

After reading over the patient's chart and talking with a few of the nurses caring for him, I entered Mr. Fitzgerald's room for our first encounter.² He was a frail gentleman with a large belly and jaundiced skin. I introduced myself. I told him I was a special nurse who had a lot of time to *listen* if he felt like sharing what it was like to be seriously ill. (He obviously could not control the cancer cells growing in his liver, but I gave him the choice of controlling whether or not he wished to talk about it.)

"Yes, thank you," he said.

"May I sit on the bed or would it make you uncomfortable?"

"No, please sit; I don't mind."

Holding his hand and looking into his eyes I simply said, "This must really be tough for you."

"Oh, it is—I pray to God you'll never have to know."

I asked him to please tell what he was feeling; to teach me what the right things were to help his time be easier.

He spoke of being denied the truth.

"Who do they think they're kidding? I know how sick I am. The other day I asked my doctor how much time he thought I had left; he just joked and left my room."

"Why do you think he did that?" I asked.

"I know, alright, because he doesn't want to tell me how bad it is."

"How bad is it, Mr. Fitzgerald?"

"Well, I'm full of cancer and I'm not going to make it out of here."

He withdrew his hand from mine, covered his face and cried. I, too, was moved and tears came.

"They come in here talking *about* me but never *to* me. They look at my chart and tell me things are looking pretty good, but they never ask me how I feel! I don't care how things look on paper! I just know I can't even walk to the bathroom by myself. I'm getting weaker and I know what that means."

"What does it mean?" taking his hand.

"Like I said, I'm not going to make it."

"What are you feeling, in your heart and soul?"

"Well, I guess we all gotta' go sometime. I just never thought it would be like this."

"What is the most difficult thing for you?"

"I guess having to be down, flat on my back. I haven't worked for

² All names are fictitious.

over a year and I've got four kids. It's hard having to be dependent on somebody for everything I need."

"What is important to you?"

"To get better!"

"You mean 'cured'?" I clarified.

"Well, that would take a miracle; I know they can't *cure* the cancer, I just want to get better; you know, up and around, so I can do for myself."

"I'd like to see that for you too, Mr. Fitzgerald. You mentioned a miracle. Could you tell me more about how that would work?"

"It would be a miracle, I would get better and the doctors wouldn't be able to explain it. It would be a miracle, from God."

I asked him about God, how he thought God fit in with his having cancer.

"I don't believe God gave me it, if that's what you mean. But I think maybe sometimes He can do miracles."

"What would determine whether or not God might perform a miracle in your situation?"

"I don't know, maybe if I was worthy or something. Are you a psychiatrist?"

"No, Mr. Fitzgerald, why do you ask?"

"Well, I just wondered. Thanks for coming, maybe we could talk some other time."

"Your saying that makes me feel like you're finished with our conversation. I have plenty of time to listen if you'd like to talk any more. Has it made you uncomfortable talking about God and miracles?"

"No, I'm just tired."

"I understand. Would you like me to return tomorrow?"

"Yeah, that's o.k."

"Would you like me to get in touch with your pastor or one of the chaplains here at the hospital?"

"No, thanks, I'm alright. See you later."

By listening attentively, you can ask appropriate questions relevant to the patient's last remarks. I am not writing a paper on "interview techniques," rather I am giving some guidelines on being a good listener. Of prime importance is that you genuinely *care*. It matters to me that the patient controls the conversation; sets the pace, so to speak, and ends when he chooses. I let him know I was quite comfortable to continue, if he chose, but that I also respected his wish to terminate the discussion.

I think the most valuable gift we can give to each other is acceptance; especially to the dying person who has no experience on which to rely. *He has never died before and so his coping mechanisms*

might not always be acceptable. Who are we to demand of anyone, especially the dying, to do things “our way”? By remaining non-judgmental of the dying patient’s choice to handle his specific situation, we are saying, “I accept you and will not interfere with you.” The tough, young farmer who wants to “fight for life” has every right to do this and it probably doesn’t matter a great deal to him whether you or I agree with him.

It does matter whether we help him do this “his way.”

I perceive this to be not my responsibility as a nurse, but my responsibility as a human being. With death we are all simply taking turns and it matters very much to me how difficult your “turn” might be. Problems are compounded by institutionalization. We rarely find the appendectomy patient demanding his right to wear his trousers during his recuperation. Never have I seen the patient who is terminally ill fighting for his right to have a glass of beer or a visit from his dog. These patients have neither the physical nor emotional energy. *It is also our responsibility as caring human beings to fight for patient’s rights.* You might ask how we know what is important. Simply ask the patient himself; not his wife, not his physician, or his minister. All these people will tell you what they *think* is best, but frequently it is a projection of what each person wants for himself. Physician and wife may secretly agree that “Frank can’t take it” and decide to withhold the truth regarding his diagnosis and prognosis.

I was involved in a case where a thirty-eight year old was undergoing exploratory surgery for a bowel obstruction. The surgeon truly was surprised to discover a malignancy spreading throughout the intestines and involving each and every abdominal organ. The wife and mother of the young man were hysterical upon receiving the diagnosis. Their choice of coping was to keep the patient heavily sedated, until he died. The surgeon obliged and within about five days it was over. Our hospital chaplain and I tried unsuccessfully to convince (I mean *convince*) the wife and mother to discuss with him what was happening. They refused, They finally resorted to placing orders on the chart that prevented me from “interfering.” I can try to understand how terribly difficult this must have been for them; I would also defend their right to cope with this death in their own way, but they were interfering with someone else’s freedom. No one sat beside Jim, waiting for him to awaken from sedation, to talk with and listen to him. *He never took part in his own dying!* He never got to see his daughter again; he never got to tell his wife he loved her. He couldn’t say goodbye. I believe no one—mothers and wives included—has the right to make a decision for another person’s life or death.

During the time I spend with my patients, I find out *what* they want, from *whom* they want it, and *when*. I don’t blatantly come out

and ask, but I am fairly straightforward. I was asked to see a forty-two year old female with carcinoma of the trachea. She was an honest and open person, very easy to talk with and taught me well. She had been hospitalized for about three weeks, running a downhill course. One Saturday I was called out of my garden to see if I might calm Joan. It seems her husband had been in a minor automobile accident and was admitted over the weekend for observation. Even though Joan had been told that Harold was not injured she was upset and working herself into breathing difficulties. I solved the problem simply by putting Joan in a wheelchair, hooking up a portable oxygen tank, and taking her to see her husband for herself. She was relieved; returned to her room and rested the whole night. Harold was detained for several days for further testing and plans were made to watch him for another week. In the interim, Joan's roommate was being discharged.

"Joannie, I've got a really nice roommate for you; if you want him!"

"Oh, Joy," she whispered. "Could we really do that?"

"Sure, I'll go talk with Harold."

Her husband couldn't have been more pleased. We talked about the possibility of Joan dying during any of the next few days that Harold would be in her room.

"Oh, hell, Joy, I was going to take her home. It might happen there. I want to be with her."

I personally carried out the transfer, scrubbing beds and signing various forms.

The nurses on Joan's floor were enraged! I'll never know why. There is no rule stating "husbands and wives cannot occupy the same room." Even if there was, I would have carried out what Joan *and* Harold wanted. In loading my guns, I chose the correct ammunition—"what do you want?; from whom?; and when?" To evaluate the caper, I returned the following morning to check on Joan. She had gone to sleep at 7:30 p.m. and slept until 7:30 a.m. without a sleeping pill or injection for pain. She and Harold ate breakfast together and for the first time in three weeks she retained the food. She grasped my hand and whispered a hoarse "thank you."

Death has an effect on us. I would emphasize at this time that no one is ever the same after he has been told he has a serious disease. Elizabeth Kubler-Ross has identified certain psychological "stages" she feels most terminal patients and their families experience.³ I suggest that you seek out her book and glean from it any useful information pertinent to the care of the dying. My philosophy is not so much one of psychiatry as it is one of advocate and friend. My ap-

³ *On Death and Dying* (The Macmillan Company, New York, New York, 1970).

proach is one of "reality therapy." I assist the patient to acknowledge his current physical status, then allow him to determine, for himself, how he is going to cope. I do not function as an analytical psychiatrist; I am not trained in that area. However, I do help the dying person regain control of whatever remaining life he may have, regardless of time. I find it irrelevant to explore how things got to be the way they are, but discuss with the patient what he wants to do now that things are the way they are. I emphasize to my patients that they aren't dead yet! I answer all questions honestly but give no information that has not been requested.

By the time the patient begins inquiring, he probably is more willing to listen to the answers. It would be futile, if not cruel, to "hit" someone with statements like "How do you feel, knowing you're dying?" or "I read on the chart that you've got cancer. Want to talk?" I have already explored the means of dignity by giving examples of "patient control" and other examples of not requiring dying patients to do it "our way." This also can be carried over to how we would prefer families to respond after a death in the hospital. Remember. Death affects us all. It conjures up uncomfortable memories. When dealing with families I use the same approach as I did with their dead loved one. No matter how the bereaved persons behave, I defend their right to respond in their own way.

While walking past the Coronary Care waiting room, I heard crying. I went in and found a gentleman and his daughter visibly upset. The woman explained that her mother had been perfectly alright last evening during visiting hours but around midnight she suffered a coronary and died. She and her father were waiting for her sister to come to the hospital. I asked if they wanted to see the body. They said, "Yes, please." I went into the coronary unit to help prepare the body. When I asked the nurses how they felt about having the family view the body, they said it was quite alright. (Sometimes staff will hide their own discomfort behind "rules of the institution.") I escorted the family to the cubicle where the body lay. Unobtrusively I remained near while the daughter went to her mother's side, rubbing the cold hand. The husband was crying and kissing his wife's body. It was distressing for them. Hours ago the woman they loved was alive and planning to go home in a few days. Now she was dead. Though I was a bit uncomfortable with them kissing the body and holding it, I allowed them to work through their initial grief. What damage can be done to a corpse? To the staff and me, this was a dead body, but to the bereaved it was someone they had known and loved for many years.

I believe nothing has such a profound effect upon us as death or dying. And Americans seem to be coping less successfully than ever. I feel it is due to the following two circumstances. First, we are a

“youth-oriented” society. We wish to have encounters only with those people who have beautiful blond hair blowing in the wind as they run through a plush meadow drinking Pepsi-Cola! If you do not have a perfect body or a perfect mind, we have institutions in which to hide you. I have a great deal of anger regarding how our society conveniently isolates *our* retarded, *our* aged, and even *our* dying.

A second contributing factor affecting our ability to deal with death is our loss of any religious commitment. What a smug bunch of theorists we’ve become! We have analyzed and philosophized so much that we have forgotten what it “feels like to feel!” We have no sense of belonging; little purpose in life. No wonder we die poorly; we have lived poorly. I sit with numerous dying patients who lament that they haven’t had enough time to live. They may be seventy years old and, *if* they had another seventy years, it still wouldn’t be enough! It’s not the quantity of time, my friend, it’s the quality.

Death is not selective. I see four-year olds die and I see twenty-eight year olds die. No one has any guarantee of living eighty years. But we can control *how* we live. The secret I have learned from my dying patients is to live life fully, every day. You or I never know when our physician, while doing a routine physical examination, might discover an occult malignancy. It happens, and, because it happens I don’t want to have to cram in a lot of living in six, short months. Most people are spending all their remaining energy on just staying alive and fighting the disease. Its too late to try to make up for thirty-three lost years. I have listened well and I have learned. I will share one lesson with you: Get involved with people; give of yourself, for in giving do we truly receive.

THE MILITARY WAY OF DEATH AND MINISTRY

Chaplain (LTC) Eugene E. Allen

For six months the residents (Chaplains Randall R. Tucker; Bobby G. Allen; Glenn P. Hall; Howard W. Johnson; Alfred Delossa, Jr; Lindell P. Smith; and Lee Frimpter) in the CPE program at the Brooke Army Medical Center, along with Chaplain Jim Thompson and me, have been studying the issue of death, dying and grief. This study has been theological in perspective and clinical in style. As we progressed together we became sensitively aware that we, as military pastors, may face a unique process when we walk with people who are dying or those who are grieving the death of another. We then began to ask the question, what do our parishioners experience that our civilian counterparts may not experience? Further, if our military community experiences a unique process, what is to be our unique ministry to them? In this paper I would like to share an abbreviated definition of some of our and my observations.

In the beginning I would affirm that, of course, the uniqueness of one's death does not immunize one from the spiritual strength that is available to all. Our military parishioners have rules, regulations, rituals and traditions that stay with them through the process of dying and go even into the national cemetery in which they are buried. There is a constant military pattern of life and death which carries with it the implications of rank, position and authority. This pattern could become routine to all of us, and then we could lose our ministry to that process. We could lose our prophetic stance, and the knowledge of the visceral struggle our parishioners experience. To make the universal strength of God's grace available to all is our goal; to place ourselves with our people in their pattern of life is our style; to share in participatory love is the substance of this relationship. It is hoped that this article could help us to so minister.

What then are the unique ways we experience death and dying? The list could be long. In this article, I will touch on only three major areas. I will survey them and assess their opportunities for our ministry. The three major areas are:

1. Our emphasis upon youth and health keeps the military peacetime community from experiencing many happenings of death. When they are experienced they are catastrophic in nature.

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2. The nomadic quality of our lives offers us a different way to minister to grief.

3. The umbrella of the Army "taking care of its own" offers a form of care that could be interpreted in the style of its benefits. The chaplain could be seen as a part of that "benefit package." The relationship would then have the potentiality of being based upon a sense of obligation on the part of the chaplain and demand on the part of the recipient.

Let us now look at these three points more closely. The Army keeps itself healthy. Our people are screened before they enter the service and are carefully monitored throughout their career. Those who suffer physically are not only out of the service but oftentimes out of sight. This is true for the young soldier in the barracks and those often who are in family housing. So when death comes it comes as a shocking catastrophe. It often comes due to a fatal accident, a recently discovered fatal disease or a disabling physical experience.

Then in the middle of all that pain and agony there often comes a termination of the grieving person's immediate environment and friends. For example, if a young soldier in training contracts a fatal disease he is immediately taken from his command and perhaps flown to a major medical center. The others in the barracks receive the news as a terrible surprise. However, training goes on, the friends disperse and the sick soldier remains behind in the transit world of a hospital. It is not too dissimilar in the world of family housing. For example, suppose a young captain experiences a fatal car accident. His wife and children are deluged with help, friends and good military administration. However, in spite of all the concern and care that can be mustered, her *future* is not in that community. She soon will leave and continue the process of grief at her home and community. The chaplain's relationship, though intense, is usually short in duration.

The chaplain needs to know at this point the skills of crisis intervention. By the definition of some, it is possible that the military chaplain's primary role is best defined as a counselor in anticipatory grief or crisis intervention counseling. It is felt that our primary ministry is helping people who face a catastrophe or loss in the early parts of their grief. Helping them to prepare the way for a future long-term ministry becomes our primary ministry. Therefore, when we do grief counseling our goals are limited by the transitory nature of our community in helping people who face a catastrophe or loss in the early parts of their long-term in nature. We can begin this journey for those who grieve. And a good beginning can be the most important part of the trip. Nevertheless, our journey usually ends or becomes limited as the next of kin moves to a new community.

Our long-term grief counseling usually happens with those military persons who lose a "significant other" back home or elsewhere. Here

the journey lengthens, our walking with the person becomes gauged by the process of working with the experiences of denial, depression, anger and acceptance. Here is when skill, love and caring are critical in the area of grief counseling.

This is done against the backdrop of our own "PCS". The counselee or the chaplain lives with the backdrop of his own termination always in mind. So as the chaplain relates to the counselee about the issue of physical death they are both sensitive to the possible relational death that will occur between them. They face not only the grief in losing the "significant other" but also the eventual grief of losing each other. They know that what occurred in death will happen eventually in their relationship.

The nomadic military world is the reality that one constantly experiences in handling grief in the military. It is so clearly seen in a chaplain who recently lost his father. He said "I was notified that my father had died. I promptly arranged for the trip back to the States, arrived home in time for the funeral which I attended, feeling breathless. After the funeral, I returned to Germany and having arrived there I asked myself, "Why did I go home?" I did not have the time nor opportunity to work through any of my grief." This is not an unusual experience for the nomadic military family. We are all geographically rootless and seeking to resolve the lost emotional roots of our past while living away from our origins. So in the process of moving, we seek to resolve our losses and subsequent grief as the people of God. The military is nomadic but it can find community in the fellowship of believers which the chaplain leads.

It is here that the chaplain can best experience meeting the opportunity of working with a person through the grief process. Here he can use the community of worship and fellowship which he facilitates to minister to the grieving person. Here the nomadic community of God can invest with another at a most important time. Perhaps there is no more significant ministry for the community of God's people in this nomadic military world than to the grieving. These people oftentimes make no verbal demands. They await a word from God and His community.

Another common element to the military way of dying is related to the benefits. Provision is made for every need from the hospital to the national cemetery. When the chaplain is called upon, he comes as a representative of God and his community. He relates to the grieving person at the level of the "I-thou". He represents God to a person as a person. He is not part of a package. He is himself with another at a time of need. It would be easy to forget this and become a benefit "thing" to recipient "thing" and avoid participation in the emotional and spiritual process.

One of the most difficult ministries in the military is to be assigned near or to a national cemetery. Day after day funerals are given by chaplains for persons they have never known, they will never see the next of kin again and with whom there is a limited relationship. In other places our ministry can often be spelled out in a similar way. Out of our awareness we could develop a feeling of obligation and easily lose our spirit of ministry. We could do what we "ought" and not what we "want" to do. This inevitably means distance, alienation and fragmentation. It means a joyless ministry to a joyless and grieving people.

In many ways our ministry is to the stranger. We relate to people we have never seen before or may never see again. Our nomadic and mobile world means we may see each other for only a few moments. Our lives touch hundreds of people in a total career of military ministry. The military community ministry is in a sense a paradigm of all of life and our ministry to that life. Feeling the fear of being a stranger is the common fear that all persons face. The ministry to this fear is most lucidly seen in our military ministry. Further, it becomes most painful and most definitive at the time of death. Here we move closest to feelings of loneliness. By the "Ruach" of God we share in the ministry of person with person. We mutually light our lamps in the darkness and walk together. Perhaps God calls us to only a short walk, but short or long no person in his grace is a stranger. At the crushing apex of death and loss we mutually meet and mutually seek divine and mystical strength.

Seeing people as people and not as strangers is central to the chaplain's ministry. Death strips away the extrinsic trappings of life. At the point of death one's rank, benefits and authority become useless. Here the intrinsic and spiritual strength of a person is primary. The chaplain serves as the facilitator of that strength. He helps the dying person to see that, with all of the things that the military offers, the facing of death is a solitary and personal matter. The chaplain is the spiritual enabler who stays with this person as he faces his needs. The chaplain is the representation of God's love and hope. He is a person who meets another person who may feel like a stranger moving through an experience of strangeness—the experience of death.

In the middle of a world full of sterile technology and precise treatment, the dying person faces his own personal and spiritual fragmentation. His guilt, his anger, his hopes, his grief are all mixed together. Who will hear? Who has a word from God?

For 201 years the Army chaplain has been the service member in war and peace, sharing in his hardship and his glory, his deprecations and his victories. The chaplain has been a bridge between men and God, between the here and now and the there and then. He stands with

his fellow soldiers upon the common single ground, looking toward the infinite. He proclaims God's love in loving the dying soldier; he announces God's presence in being present with the grieving family; he asserts the unchanging presence of God to the nomadic-feeling community, and he calms the fear of being a stranger by remembering, sharing and caring. In the face of death such love is creative. The military way of death is ultimately met with the ageless process of God's love and peace shared by his representatives.

The participatory style of ministry is analogous with the term military chaplain. The genius and uniqueness of our ministry is found in our model of participation. We wear the same uniform, we experience the same struggles and victories, we interface with the same command structure and experience similar demands and expectations. Our very ministry defines a theology—A theology of presence, of sharing and of participation.

Some of the thanatological thinking of today has a way of categorizing one's adaptation and resolution of life and death. Our CPE group has experienced this as an elusive goal. The definition of resolution has many different facets. Further, once the definition is found, it is most often used as a tool to put the dying person into a category or a stage. Then, the chaplain is likely to move toward a ministry of defining rather than relating, analysing rather than participating, observing rather than loving. To know and understand the dying person is critical. However, our major focus has been on our style of ministry rather than emphasizing the stage of resolution for the patient.

Our military model of participatory ministry means more than wearing a similar uniform. Our uniform is a symbol of our participating ministry. We are involved with our people. We are with them in a sense of emotional and spiritual struggle. Participation is our goal, direction and process.

Our CPE group came to see our ministry to the dying person best evaluated not by defining a level of resolution for the dying person but by defining the level of warmth, empathy and participation on the part of the chaplain. We see the dying person and his next of kin changing daily in their feelings and thoughts. They emerge and regress in coming to terms with death and their future. To categorize them in this process is possibly to miss them. At Gethsemane Jesus faced His death. His request of his disciples was to "watch with Him." This seems to be the request of all persons at their own Gethsemane—"watch with me."

So we began watching by looking at our own feelings about our own death. For two days we participated in an experiential death seminar. It was heavily laden with emotion as each student went through exercises that helped him face the termination of his own life. We did

not talk “about” death but experienced, through fantasy, our own death. Our study of thanatology became our own thoughts, feelings and goals.

The results were a unanimous desire to affirm life. Each of us affirmed a deeper claim for the importance of time. We renewed the importance of relating to our families, our vocation and our spiritual values. Through experiencing the dread of our own death we affirmed the celebration of life. In being aware of our own feelings we felt better able to participate in the death of our people. Our goal came to love, to care, to share in a non possessive way in the name of our God. All other goals became secondary. To walk in the valley of the shadow of death is best resolved when He is with us. The chaplain represents the creative presence and love of God. He walks with the dying person when he seems to face the most unresolvable issue of life. He participates with the dying person as one who accepts him with all of his pathos. He watches with him.

When we focused primarily on the patient we found ourselves doing much talking, observing and analyzing. When we began with our own investment of participation in another’s death we did creative ministries that affirmed both the dying person and our vocation.

Our nomadic military faces death in many ways similar to other societies. Nevertheless, where our people experience uniqueness they experience hardship. They often face greater aloneness, separation and alienation due to the nomadic quality of military life. Our vocational call is to participate in His name with His people. Our goal is realized as we journey with those who hurt, who grieve and face death. We have no other destination than to walk. Our heritage is filled with chaplains who have walked. They have walked in heroic ways on battlefields, quietly in hospital rooms, patiently with their friends who share with them from afar. Our military community needs are best met as we meet our call to participate—a participation of spiritual leadership, friendship, comradeship, vulnerability and hope.

In conclusion, we recently experienced our own grief process in the death of our friend, Chaplain (LTC) Jim Griffis. During a surgical procedure he experienced a dramatic turn around and died here at our Medical Center. We dedicate this article in memory of him and in gratitude for his participatory ministry as seen in his vibrant life, in his CPE supervision at Fort Sill, and in his readiness to share himself with others. His life meant much to us, his death was felt with pain and our prayers for his wife and children are given often.

SUICIDE: PREVENTIVE AND SUPPORTIVE MINISTRIES

Kenneth R. Mitchell, Ph.D.

This morning I sat listening to a young psychiatrist discuss his work with a troubled family. They had sought his help because their sixteen-year old son was frequently truant from school. Suspecting that the parents were over-reacting to what is after all a rather common problem, he asked them why they were so upset with Jim's truancy.

"Well," replied the mother, "our other son had similar problems when he was a teen-ager, and he wound up committing suicide at the age of twenty. We don't want that to happen to Jim, and we're taking no chances." The parents were sure that their older son, John, had given them signals that he was disturbed enough to commit suicide, and they had missed those signals. This time they wanted to be sure they responded in time.

Anyone who has dealt with the aftermath of suicide will reverberate to the problem the doctor described. How can any one of us recognize the signs of impending suicide? How can we prevent it? How can we deal with the family that is left behind after a suicide? It is a problem that many military chaplains have already had to face, and those who have not yet faced it stand a good chance of having to do so at some time in their ministry. There are no firm, definite answers to the questions I have written above, but there *is* useful information and there *are* guidelines. In this article my purpose is to share what I consider to be the most important of those guidelines. In order to do that I shall also need to deal with some truths and falsehoods about suicide that are quite common.

THE QUESTION OF INTENT

Suicidal acts, according to my late colleague Thomas W. Klink,¹ may be divided into four categories. The diagram below illustrates the four types of suicidal act.

Type A is the person who really intended to die, and who succeeded in the suicide attempt. These people may be called *the determined*

¹ T. W. Klink, a personal conversation.

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	Meant to Die	Did not Mean to Die
Died	A	B
Survived	C	D

ones. Type A persons often choose a violent form of death, one which may even threaten the lives of others.

Type B is the person who died but did not really mean to die. Such persons often time their suicide attempt in the hope that a friend or family member will find them in time, and will save them. But the meeting lasted overtime, or the staff car had carburetor trouble, and the intended savior was too late. This category, Klink said, accounts for more than 90% of actual suicidal deaths. The suicide was intended as a warning signal: a high-risk, high-stakes warning signal.

Type C, often referred to as *the bunglers*, really intended to die but were saved in time, or the grenade failed to explode. The most important thing to know about the Type C person is that he or she will almost certainly try again.

Type D is the person who issued a successful warning. He or she may not try again unless life once again becomes painful or difficult. In shocking and warning those around him, the Type D person succeeds in what he intended to do, and therefore there is little need for a repeated attempt unless those around him somehow fail to catch the signal.

But when we divide suicidal acts into these types, there are several cautions we need to remember. Although a huge proportion of suicide attempters do not mean to die, and a very small percentage do wish to die, this distinction is only unconscious. *Consciously* what is available to the attempter's awareness is that he wants to die, and that is what he will often say if he survives. The chaplain, or any other helper, cannot afford to take the risk of casually assuming that the suicide survivor is a Type D person, and of relaxing his helping efforts.

In fact, the question "Did this person really mean to die?" is too narrow a question; since it is too narrow, it does not help. What does help is a different question: what does this person intend? The person who actually makes a suicide attempt, whether successful or not,

usually signals that he or she is in trouble. At first the signals may be ambiguous. If the desired help or intervention does not come, the stakes will be raised until the loudest signal of all, the suicide attempt, is finally resorted to.

SIGNALS OF AN IMPENDING SUICIDE ATTEMPT

Probably the single most important kind of knowledge for the chaplain is a clear understanding of what the signals are that may precede a suicide attempt.

Depression is the first such sign. By depression, however, I mean not only the general appearance of a person that leads us to say he seems depressed, but also some specific things the chaplain can inquire about.

Does he have sleep disturbance? That is, does he sleep poorly, have dreams that waken him, stay up very late at night, go to bed very early, stay in bed too long in the morning, get up far too early? And particularly, have any of these signs come about recently? A man who has always been a night owl need not alert us, but a man who never was a night owl but is one now should alert us.

Does he have appetite disturbance? That is, has he recently begun to pick at his food and eat little, or has his appetite suddenly increased noticeably? Either one of these may also be a sign of depression.

Are his body movements actually somewhat slower than usual? Psychologists call this sign "psychomotor retardation," and it is an important sign. The person who has literally slowed down a lot may often be depressed.

Depression by itself is common enough. We all get depressed, and we all show the same signs I have discussed above. Mental health specialists often say that depression is to mental illness what the common cold is to physical illness: bothersome and uncomfortable but not of itself dangerous. But depression is a sign that something is wrong, and may be an early forerunner of a suicidal attempt.

Grandiosity is a second and more noteworthy signal. It can have two main roots; either it is a condition that alternates with serious depression (and so should be thought of as a potential suicide signal) or it may be drug-induced. A drug-induced grandiosity can lead to suicide because the person who is high on drugs may believe in his own indestructibility and will therefore take risks that are literally insane. In either case, the unrealistically grandiose and boastful person is a candidate for a suicide attempt.

Talking about suicide must always be taken seriously. I hope that everyone knows by now that the person who talks about suicide often *does* attempt it, and that the old myth about talkers never doing it is

absolutely false. As a general rule of thumb, it is usually the case that the person who has thought about *how* he will commit suicide is closer to doing it than a person who has not thought about that but has only expressed a general thought of wishing to die.

The person who *has the means* to commit suicide is a high risk. Whether or not someone has the means may not always be easily apparent, but you should be alert for any signs of knives, guns, ropes, drugs, or other potentially lethal items in unusual quantity. In the military, where death-dealing materials are present in certain places in high quantities, this is a particularly puzzling problem, and you may not be able to rely on this signal.

TIMES OF HIGH SUSCEPTIBILITY

Suicide attempts of all kinds are essentially responses to the sense that something has gone wrong. But the sense that something has gone wrong is a phenomenon that overtakes all of us at various times. If we can identify the moments when this kind of stress is most likely and most potent, we shall also be identifying the times of greatest susceptibility to suicidal impulses.

Theoretically, that is not a terribly difficult task. We can in fact identify the moments of highest susceptibility by referring to one word: change. When a human being is deeply affected by change, he is at his most vulnerable. The difficulty lies in our own ability to recognize, and to be sensitive to, moments of change.

For the military chaplain, some such moments are readily identifiable, such as permanent change of station or going on temporary duty away from the station. Working some years ago with the chaplains at Forbes Air Base near Topeka, I had occasion to deal with Air Force personnel and their families. There was a mapping unit stationed at Forbes, and whenever a significant detachment of mapping personnel went TDY, we could count on suicide and suicide-like gestures to increase. The rate of disturbance was similarly higher in newly arrived personnel coming to Forbes as a PCS.

Those situations, however, are rather blatantly visible examples of change. In addition to them, the chaplain should be aware of the following situations as potentially creating susceptibility to suicide:

- change of responsibility
- promotion (!)
- impending retirement
- major personnel transfers among subordinates (One captain made an abortive suicide attempt three weeks after the three highest-ranking enlisted men in his outfit were transferred.)
- introduction of new systems of accounting or reporting

—change in immediate superior

—graduation from (or flunking out of) specialty schools

The above list requires two particular comments. First, I should note that the list itself refers specifically to military personnel themselves. But it should be immediately apparent that the same circumstances can and do create susceptibility not only in military personnel but also in their families. I know of two very similar cases in which the transfer of a lieutenant colonel created a situation in which there were suicide attempts in the families of officers who had previously reported to the two colonels in question. What happens is that the distress caused by a change in superior officer is literally passed on to the family of a subordinate, while the subordinate himself seems to remain very well in control of his attitudes. The mechanisms by which this takes place are the province of family systems theory, and there is not space to explore them here.

The second comment concerns the exclamation point which I inserted after the word “promotion” in the list. Some readers may find that one a bit hard to believe. But Dr. Harry Levinson has pointed out that in any organization promotion often creates serious personality stress,² and suicidal or suicide-like behavior is known to result. Where promotion is simple advancement in rank, the risk is less than where promotion means assumption of command or the taking on of new responsibilities.

In addition to change, there are other factors that make suicide more likely. One of the most important is isolation. Herbert C. Modlin points out ³ that this is particularly true of suicide among adolescents and young adults. Referring to a study of suicide among youth in New Jersey, Modlin notes: “The most significant factor related to suicide among school children was that, in every case of suicide in the study, the child had no close friends; . . . an indication of social isolation.” ⁴

SUICIDE-LIKE BEHAVIOR

In the previous section I introduced the term “suicide-like behavior.” This behavior is different from actual suicide attempts; but it is important to be able to identify suicide-like behavior because those who engage in it are a high-risk group for suicide itself.

A suicidal attempt is behavior engaged in by someone who has a conscious intent to die immediately and wholly. He or she intends his or her own death, and intends that it shall happen at a particular

² Levinson, Harry, “What Killed Bob Lyons?” in *Harvard Business Review* 41:1, 127-144, January-February 1963.

See also Levinson, Harry, “On the Way to the Top”, in *Are You Nobody?* Richmond: John Knox Press, 1966.

³ Modlin, Herbert C., “Cues and Clues to Suicide.” *Menninger Perspective* 1971.

⁴ *Ibid.*

moment. Suicide-like behavior, in contrast, is not aimed at the total destruction of the self or at that immediate result; like suicide, however, it is essentially self-destructive.

Suicide-like behavior may ultimately end in death. For example, drug abuse and alcoholism (which is the primary form of drug abuse in American society) are self-destructive, even when a particular instance of drug ingestion does not end in immediate death. Of the alcoholic we may say that he is destroying himself by degrees. (In fact, we often do say just that.) He is not directly committing suicide, but his behavior has a fair chance of ultimately causing death. The same thing may be said of the kind of person Wayne Oates calls a "workaholic," whose high-tension, driven lifestyle contributes greatly to the possibility of heart attacks.

It is also possible to engage in suicide-like behavior which may not end specifically in death but which nevertheless is self-destructive because it kills something central in a man's life: his career, or perhaps his ability to perform physically. We occasionally recognize this in the behavior of an officer who engages in blatant adultery or deliberate flaunting of a professional code, by saying of him that he is "committing professional suicide." We mean, of course, that he may well kill his career, with the danger that without his career his life will cease to have much meaning for him.

The person who engages in suicide-like behavior is a person with high potential for actual suicide. The alcoholic is vulnerable in this way, particularly just after he has stopped drinking. (That is because he has given up his major problem-solving technique. At such a point he needs tremendous amounts of support and social contact.) The hard-driving workaholic is similarly vulnerable, particularly just after he has failed at something.

Let us for a moment sum up where we have thus far come. We have identified the kinds of people who are most vulnerable; we have identified the times in life when vulnerability is high; and we have identified some of the most important signals that should alert us to suicidal potential. These all fit together. Suicide-like behavior or a previous suicide attempt is not just a description of the people most prone to try suicide; it is also a signal to the chaplain to be on the alert. The situations, such as change and isolation, that seem to make people particularly vulnerable are not just descriptions of a situation; they, too, are signals. But what are we to do when we encounter such signals?

THE CHAPLAIN'S INTERVENTION

I am tempted at this point to play a word game and to say that the best form of intervention by the chaplain is to intervene. The Latin

roots of the word *intervene* mean to “come between.” That is indeed what the chaplain most needs to do: to come between the suicidal person and his or her suicidal act. That may sound like I am, indeed, playing a word game; at least, the argument seems to go around in a circle. But the point is serious; for the greatest single error we tend to make when we suspect that a suicide is in the offing is to hold back and do nothing.

In part, this tendency to back off may stem from doubting our own perceptions. We may be unsure of what we think we are seeing or hearing. In part, it may stem from the false hope that, left to themselves, things will clear up. That is understandable but ostrich-like. In part, doing nothing may also stem from the old and quite false belief that to mention suicide to someone may put ideas into his head.

Obviously, it is insensitive just to walk up to someone and ask: “Are you planning to commit suicide?” But the chaplain is a pastor, and one of the major things that distinguishes pastors from the members of other professions is the right of initiative and access, as my colleague Dr. Paul Pruyser puts it. We pastors not only have the right but also the obligation to take initiative in relationships with other people: to inquire, if an old-fashioned phrase is not offensive, into the state of their spiritual health.

Within an established pastoral relationship, *you should not hesitate to ask someone if he or she has thought of doing away with himself*. If they have not done so, we will not be putting ideas in their heads. If they have done so, the question is absolutely urgent and is the first step in prevention.

It is often very helpful to inquire further: “Has a means of suicide crossed your mind?” The person who has thought about *how* to commit suicide is much closer to the act than the person who has only thought about whether to do so.

If you receive positive answers to either or both of these questions, you should not hesitate to act. In cases where the person seems restless and agitated, you should not be reluctant to use your authority as a pastor or as an officer or both to get the person to medical help.

But sometimes acting does not have to mean anything so drastic. If other signs are not present, or if you see significant signs but get a denial from the person you are concerned about, acting means establishing an ongoing relationship and making it possible for the person to talk with you regularly and frequently.

Do not attempt to be the only person who deals with the potential suicide. It is important to enlist the help of others: families, buddies, superior officers, and anyone else who has regular contact with the person you think is suicidal. They should be alerted to what the problem is, to watch for signs of further trouble. They should all know

of each other's existence and information, and the suicidal person should know that others know and are concerned about him.

If he gives any of the so-called "final signs"—giving away possessions, taking out extra life insurance, making a will, acting as though he is going on a trip—move and move quickly to get him into the care of a doctor. Hospitalization may be very important.

It is also important to remember that the person who is coming close to a suicide attempt may be rude, may tell you that he is all right, and may in other ways reject your concern. Handling such attitudes requires sensitivity and skill. You may indeed be intruding into the life of a person who is not suicidal. But very often such behavior is a test; the person clings to his loneliness and tries to prove that he is not worth your time. It is a sick echo of Peter's words in the fifth chapter of Luke: "Depart from me, for I am a sinful man." The Lord did not leave Peter alone, and neither should His ministers leave alone people who are convinced of their worthlessness.

THE FAMILY OF THE SUICIDE

It should be clear that no one can really prevent a particular suicide, at least not in the sense that we can count on ourselves and our interventions to work perfectly. We can follow the clues that I have mentioned in this article, and we can pray that our efforts will be successful. But the time may come when it does not work. When that happens, or when a suicide occurs without your knowing about the possibility beforehand, then the chaplain's task shifts. For at that point we are involved in a special form of grief ministry to the families left behind.

The ministry to the family of a suicide is, first, a grief ministry, and most chaplains are accustomed to that form of work. But it also carries with it special features, usually exaggerations of the problems encountered in ordinary grief situations.

Most experts on grief agree that its underlying dynamics are very much like those of homesickness, nostalgia, and depression. These other grief-like phenomena, and grief itself, are large-scale reactions to significant loss. All loss reactions, including grief, evoke three major feelings to which the chaplain has an opportunity to minister.

The first, best-known, component of grief is the sense of pain. It simply hurts to have something or someone permanently torn out of one's own life. Some of this pain may be masked by theological intellectualizing, as when a bereaved person focuses so entirely on the hope of the resurrection that the ordinary pain which ought to be there and ought to be expressed (cf. John 11:35) is denied.

The second (and much more often denied) component of grief is anger. Try as we may to deny it, the loss of someone important to us

always calls up angry feelings. Anger may be directed at society, at the Army, at God, at the enemy, and even at the person who has died. Grief cannot be said to be over until the anger has found appropriate expression.

The third component of grief is guilt. When someone close to us dies, we are forced to examine our own consciences to see what part we may have played in the death. And again, grief cannot be passed until that guilt is examined and expressed.

But in the case of a suicide, the balance among these three feeling components of grief is often different from the reaction to a non-suicidal death. The guilt, for example, may get way out of hand. Members of the family, acquaintances in the same work unit, and sometimes superior officers may blame themselves unnecessarily. "If only we had recognized how bad he felt." "I knew he was depressed and I didn't do anything about it." These two sentiments are very often heard after a suicide. Sometimes it feels intolerable to let the burden of the responsibility for suicide rest upon the person who has died, and we take on more than our share of that responsibility.

Angry reactions to a suicide also may get out of hand. Some family members may become extremely angry at each other, or at the suicide himself, and particularly at the service. One hears the claim that "his superior officer drove him to it," or that "the whole military system" drives people to suicide. What is important in a ministry to family members is to refuse to become judgmental with them about their anger. The accusations they level are in all likelihood untrue as to fact (there are, of course, exceptions) but they are reflections of real feelings and must be accepted even when one sees that they are distorted. The anger is like pus; if not evacuated, it will fester all the more, but if evacuated will permit healing.

The pain aspect of grief is also distorted after a suicide. This is particularly true for those Christians who believe that by his act the suicide has deprived himself of the chance of participating in the resurrection.

What we see, then, is that in the aftermath of suicide the same feelings that always follow a death are present, but often in highly exaggerated, distorted, and irrational form. What may be difficult for the chaplain is to accept these "more intense storms of grief" and respond to them without his own harshness of judgment or his own sense of anger and guilt getting in the way. What may also be difficult for the chaplain is to tap the feelings of those who are so "numbed" by the suicide that they cannot, temporarily, express any feeling at all.

We need to remember that the feelings which are not expressed are usually poorly handled, and that the expression of them is central to the exercise of a competent grief ministry. The chaplain may do well to

remember the loud cries of guilt, anger, and pain that so clearly mark the Psalms. The psalmist often begins with such a cry (for which the only good word I know is the Yiddish “*GESHREI*”) after which God’s comfort gradually comes.

We also do well to remember that the exaggerated aspects of anger and guilt were part of the intent of the suicidal person in the first place. Suicide, said Dr. Karl A. Menninger ⁵, is the summation of three wishes: the wish to die, the wish to kill, and the wish to be killed. Thus it is always in part a hostile act against those left behind. The suicide may well have wanted people to feel guilty, to believe that they had let him down, and his killing of himself is in part a means of killing others, too. To the extent that those left behind partially perceive this intent, it creates for them an added burden. For whatever was wrong between persons can now never be set right in this lifetime. Suicide is a permanent blocking of forgiveness, and that may become intolerable for those who grieve. In this context the chaplain’s effort to elicit and to minister to profound feelings becomes particularly important.

This also points us to this one final component in the ministry to those left in the aftermath of suicide. Forgiveness—not a cheap, quick denial of feelings but a deep forgiveness that has looked at the pain, anger, and guilt openly—is the ultimate aim of our ministry in such situations. The suicide has said in effect that he cannot forgive those around him. But with a sensitive ministry, they may eventually be able to forgive him personally and to commend him to God’s forgiveness, as well.

⁵ Menninger, Karl A., *Man Against Himself*. New York: Harcourt Brace, 1938.

THE CHAPLAIN DISCUSSES DEATH WITH CHILDREN

Rabbi Earl A. Grollman, D.D.

Modern adults are convinced by the teachings of mental hygiene that they should be honest in discussing the biological processes of birth. But when it comes to life's end, they fall strangely silent.

Of course, it's not really strange. In other eras death was an integral part of life. Old people (and younger people, too) died at home surrounded by friends and family. Rural inhabitants were closer to nature where they were regularly confronted with the death of plants and animals. Religious beliefs which once could offer total—or near total—solace have been noticeably shaken. The word *D-E-A-D* has become the new four-letter word of pornography. We blush to speak of death and dying.

Youngsters' feelings and perspectives are especially overlooked in our death-denying, death-defying culture. A recent study has demonstrated that 44% of children were not even told of the death of a significant other! After all, the adults were struggling with their own grief and could not possibly believe that youngsters would understand the tragic situation.

Not only parents, but chaplains, too, may heighten the feeling of the child's isolation. We comfort the adult mourners but pay scant attention to the "little ones." Too many ministers hide behind a variety of masks in order to avoid genuine person-to-person encounters.

The easiest and most obvious is the mask of theological language. To the young child we spew out such words as "immortality," "grace," and "resurrection," when such abstruse concepts are difficult for adults and even clergy.

Then there is the mask of ritualized action where we rightfully participate in external age-hallowed traditions but wrongfully neglect personal relationships. Isn't it easier to utter a general prayer than share intimate anxieties? We may neglect the most significant of inner, spiritual questions in the midst of outer ritual: "How do you really feel with what has happened?"

Before counseling others, we must confront death for ourselves. I have had the opportunity of conducting hundreds of clergy seminars. Many tell me that they publicly affirm a conventional conviction about death but privately have gnawing doubts and fears. When *someone*

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else's mother dies, they say that she will live eternally. When death occurs to *their* mother, they may mourn a woman irretrievably dead, or they spin out a theology of heavenly happiness for *others*. When it strikes them, a hopeless finality fills their heart. Maybe the time has come when *all* must finally admit that, concerning the complete mystery of death, we *finite* people have but conjectures not omniscience. God alone is *infinite*.

Surprisingly enough, if we but attempt to comfort the children who have sustained tragedy, we clergy can learn from these youngsters. *All* of us share the same emotions. Usually, their grief is more honest without sophisticated coping mechanisms of defense. As Emerson observed in his journal, "Sorrow makes us all children again."

Can children really understand death?

A child growing up today is all too aware of the reality of death, perhaps more than we realize. Even at a very young age, the youngster is confronted with that process when life no longer exists.

A pet is killed. A funeral procession passes by. A grandfather dies. A leader is assassinated. And, of course, there is the television tube with the picture of death in living color.

The child encounters death in many forms. He should be given the opportunity to participate with his family in the commemoration of a deceased loved one. Silence only deprives him of the opportunity to share grief.

But if the adult is confused, then how can he help the child?

Of course the adult does not understand the complete meaning of death. Theologians continue to wrestle with this thorny question. No mortal has ever pierced the veil of its great secret. Yet, we have the inescapable responsibility to share with the youngster the fragments of our experience and knowledge. There is no justification in leaving the bewildered children to muddle through as best as they can.

While insight is a gift, we must first place ourselves in a position to receive it. We must prepare ourselves for it. We must be quiet and learn to listen. We must sit down and watch children while they work and play. We must observe them in action and hear the tone and timbre of their voices. The youngsters should be encouraged to tell us how they feel about death, what they think, what they know, where they need to go. We should respond by trying to let the youngsters know that we understand what they are trying to say. We should attempt to answer the question in the spirit in which it is asked.

Do not teach the child as if we have final answers which he must accept. We show our religious maturity when we respond: "Are you surprised that I do not know everything about death? Don't be. Yet,

we can still talk about it. You can learn something from me. I can learn something from you. We can teach each other."

Can youngsters understand the meaning of death?

The terms "dead" and "die" are common in young people's vocabulary. But these words may conjure up divergent meanings.

Psychologist Maria Nagy, studying Hungarian children in the late 1940s, discovered three phases in the child's awareness of mortality. She learned that the child from three to five may deny death as a regular and final process. To him death is like sleep; you are dead, then you are alive again. Or like taking a journey; you are gone, then you come back again. This child may experience many times each day some real aspects of what he considers "death," such as when his father goes to work and his mother to the supermarket.

Between five and nine, children appear to be able to accept the idea that a person has died but may not understand it as something that will happen to everyone and particularly to themselves. Around the age of nine and ten, the child recognizes death as an inevitable experience that will even occur to him.

Of course, these are all rough approximations with many variations; but they may prove of value when children raise questions. Nagy's investigation also demonstrated three recurring questions in the child's mind: "What is death?" "What makes people die?" "What happens to people when they die; where do they go?"

Dr. Robert Kastenbaum points out the interesting fact that some adolescents and adults have childlike views of death. They "know" that death is inevitable and final, but most of their daily attitudes and actions are more consistent with the conviction that personal death is an unfounded rumor.

Should we share religious convictions with our child?

Of course! Religion is concerned with the mystery of death as well as the meaning of life. But in giving religious interpretation, a most important consideration is honesty.

Avoid theological abstractions which would only confuse the youngsters. Concepts must be translated into the language and comprehension of the child. It is neither necessary nor possible that the child accept the totality of our religious philosophy. One cannot legislate theology.

Suffering and death should not be linked with sin and divine punishment. Children experience enough guilt without an added measure of God's chastisement.

Are fairy tales a helpful explanation for the enigma of death?

The question arises constantly about what we should tell a child when death occurs. Should we avoid acknowledgement that the person

has died? Should we suggest that a grandfather became ill and had to go away to a hospital where he could recuperate and become cured, hoping that his memory would gradually fade away and the youngster would come to accept the absence as being the norm?

Evasions indicate the uncertainty which the chaplain has about the child's capacity to deal with existing situations. It encourages the youngster to develop the capacity to "forget about things," and does not prepare him to deal with life's realities. We should never cover up with a fiction which we will someday repudiate. There is no greater child need than trust and truth.

How about, "Mother has gone on a long journey" instead of the harsh words, "Mother has died."

To say, "Your mother has gone away for a long journey for a very long time" is geared to provide some solace and ease the strain of his mother's disappearance. But the child might interpret this explanation to mean that his mother has abandoned and deserted him without saying "good-bye." Far from being comforted and holding dear the memory of the deceased, the child may react with anger and resentment.

The youngster could also develop the delusion that someday the mother will return. Or unconsciously he may assume, "Mommy didn't really care enough about me so she stayed away." And if the mother only went away on a journey, why is everyone crying?

Or, "God took Daddy when he was so young because your father was so good that he wanted your father for himself."

Do you really believe that there is a relationship between longevity and goodness? The righteous may surely die young but he can also live to a ripe old age. Read the book of Job again.

One little girl said: "Don't Mommy and I need Daddy more than God?" The child developed a deep resentment against a God who capriciously robbed her of her father. The youngster became upset with the thought: "But God loved me too; maybe I'll be the next one He will take away."

What about the use of the word, "heaven", as the new abode of the deceased Father?

Heaven is a difficult concept for a child to handle. One youngster asked: "Mother, if Daddy is supposed to be in heaven, then why are they putting him in the ground?" One should share religious resources but must be prepared for further elaboration of simplistic theological terms.

Is death like sleeping?

It is only natural to draw the parallel. Homer in the *Iliad* alludes to

sleep (*Hypnos*) and death (*Thanatos*) as twin brothers, while many of our religious prayers entwine the ideas of sleep and death. Be careful, however, to explain the difference between sleep and death; otherwise, you run the risk of causing a pathological dread of bedtime. There are children who toss about in fear of going to “forever sleep,” never to wake up again. Some youngsters actually struggle with all their might to remain awake, fearful that they might go off to the deceased’s type of “sleep.”

Understandably, it is easier to respond with fictions and half-truths that will make us clergy appear to know all the answers. But the secure chaplain has no need to profess infinite knowledge. It is far healthier for a child to share the joint quest for additional wisdom than for an immediate curiosity to be appeased by fantasy in the guise of fact.

How should the facts of death be explained to the child?

The answer can be expressed in two words: *naturally* and *lovingly*.

You might initiate the conversation by citing a Bible story or by talking about the flowers growing in the spring and summer only to be followed by their fading away in the fall and winter seasons. This is the sequence of life. For all living things there is a time to grow, flourish, and then to die (Ecclesiastes 3:1).

Explanations should be presented without lurid, gruesome, or terrifying description. Proceed slowly and simply, step by step, with patience and gentleness. Fears will be lessened when the discussion is initially focused not upon the morbidity of death but upon the beauty of life.

When should the offspring be told of the death of a loved one?

It is important that the youngster be told *immediately*. If possible, he should first receive this information from a parent or from someone close to him. The minister is an ideal person, if he has a relationship with the youngster. It is wise to hear the sad news in familiar surroundings, preferably in his own home. A delay in informing the child makes it all the more likely that he will be told of the death by the wrong person, in the wrong way, at the wrong place.

Should the youngster go to the funeral?

Death is sad, but sadness is an integral part of the life cycle. The funeral is an important occasion in the life of the family. The youngster should have the same privilege as any other member of his household to express his own love and devotion. To deprive him of a sense of belonging could well shake his future mental health.

Explain in advance of the funeral the details of the service. The offspring is more relaxed and less disturbed if he first understands

what he will soon witness. All the emotional reactions that a child is likely to express—sorrow and loneliness, anger and rejection, denial and guilt—are considerably lessened when the youngster knows what is occurring and that adults are not trying to hide things from him.

No matter how helpful and therapeutic the funeral the child should not be forced to attend. If the apprehensive youngster elects to remain at home, don't place any additional "shaming" pressure upon him. Gently suggest that perhaps sometime later he might visit the cemetery. When the funeral is over, he should be given the opportunity to remain with the family and share their grief.

In my own religious school a funeral director is invited to speak before the students as to the details of funeral service. A visit then to the mortuary is strongly recommended.

Do children experience grief?

Mourning and sadness are appropriate emotions for people of all ages. The more meaningful the relationship, the more intense the feeling of loss. To feel depressed and melancholy is not abnormal.

According to Dr. John Bowlby of Tavistock Clinic, London, each child may experience three phases in the natural grieving process. The first is protest when the child cannot quite believe the person is dead, and he attempts, and sometimes angrily, to regain him. The next is pain, despair, and disorganization when the youngster begins to accept the fact that the loved one is really gone. Finally there is hope, when the offspring begins to organize his life without the deceased.

Should the child be discouraged from crying?

Only the insensitive could say of the child who had encountered tragedy and remained dispassionate: "The youngster is taking it so well. He never cries."

The son and daughter whose loved one dies should be allowed to express their grief. It is natural. They loved him. They miss him. To say, "Be brave!" sounds as if one were minimizing their loss.

Don't be afraid of causing tears. It is like a safety valve. So often parents and friends deliberately attempt to veer the conversation away from the deceased. They are apprehensive of the tears that might start to flow. They do not understand that expressing grief through crying is normal and helpful.

Tears are the tender tribute of yearning affection for those who have died but can never be forgotten. The worst thing possible is for the child to repress them. The youngster who stoically keeps his grief bottled up inside may later find a release in a more serious explosion to his inner makeup.

What are other responses to death?

For the youngster, death may bring a variety of reactions. *Denial:*

"I don't believe it. It didn't happen. It is just a dream. Daddy will come back. He will! He will!"

The child may frequently look as if he were unaffected because he is trying to defend himself against the death by pretending that it had not really happened. We may even feel that the youngster's apparent unconcern is heartless. Or we may be relieved and feel, "Isn't it lucky! I am sure he misses his father, but he does not seem to be really bothered by it." Usually the lack of response signifies that the child has found the loss too great to accept, while he goes on pretending secretly that the deceased is still alive. *Bodily Distress*: "I have a tightness in my throat!" "I can't breathe." "I have no appetite at all." "I have no strength." "I am exhausted." "I can't do my homework." "I can't sleep." "I had a nightmare." The anxiety has expressed itself in physical and emotional symptoms. *Hostile Reactions to the Deceased*: "How could Daddy do this to me?" "Didn't he care enough for me to stay alive?" "Why did he leave me?" The child feels deserted, abandoned, and angry. *Hostile Reactions to Others*: "It's the doctor's fault. He gave him the wrong medicine." Or, "Mother didn't take proper care of him. That's why he died." The resentment is projected outward in order to relieve guilt by making someone else responsible for the death.

Replacement: "Uncle Ben, do you love me, really love me?" The child makes a fast play for the affection of others as a substitute for the parent who has died.

Assumption of Mannerisms of Deceased: "Do I look like daddy?" He attempts to take on the characteristic traits of the father by walking and talking like him. The boy may even try to become the head of the family and the mate of the mother.

Idealization: "How dare you say anything against Daddy! He was perfect." In the attempt to fight off his own unhappy thoughts, the child becomes obsessed with the father's good qualities. The falsification is out of keeping with the father's real life and character.

Anxiety: "I feel like Daddy when he died. I have a pain in my chest." The youngster becomes preoccupied with the physical symptoms that terminated the life of the father. He transfers the symptoms to himself in a process of identification.

Panic: "Who will take care of me now?" "Suppose something happens to Mommy?" "Daddy used to bring home money for food and toys. Who will get these things for us?" This state of confusion and shock needs the parent's supportive love: "My health is fine. I will take care of you. There is enough money for food and toys."

Guilt: Children are very likely to feel guilt since in their experience, bad things happen to them because they were naughty. The desertion

of the parent must be a retribution of their wrongdoing. Therefore, they search their minds for the "bad deed" that caused it.

Many young children harbor all kinds of fantasies that they are responsible for the death in the family. They believe in a primitive magic. That is, if one wishes someone harm, the belief will bring results. The boy said to his sister: "I wish you were dead." Then when the sibling died a year later, the lad was terror stricken by his own powers. Or the youngster may fear that he made his mother work too hard. He can still recall her saying: "You're such a messy kid. Picking up after you will be the death of me yet." This is why it is so necessary to help the child express his own fantasies and fears.

These are some of the reactions of children as well as adults. Some may never appear. Some come at the time of crisis. Others may be delayed, since so often the child represses his emotions and attempts to appear calm in the face of tragedy. As chaplains, we can give vital support for the terrible pain of separation.

GUIDELINES FOR THE CONCERNED CHAPLAIN

1. *Do Not* avoid the subject of personal death in your discussions and sermons. The mental health of us all is not the denial of tragedy but the frank acknowledgement of painful separation.
2. *Do Not* wait for the occurrence of death by preparing for that inevitable moment in life. Encourage others to plan for the necessary details of funeral director, cemetery, wills, insurance, organ transplantation. And formulate your own plans as well.
3. *Do Not* discourage the emotions of grief. Anger, tears, guilt, despair, and protest are natural reactions to family disorganization. Never be so cold to human feelings that you do not accept the emotional reactions of those who hurt.
4. *Do Not* close the door to doubt, questioning, and differences of opinion. Respect the other's unique personality for in the long run it is he or she who must discern the meanings to the questions of life and death.
5. *Do Not* tell a person (especially a child) what he or she will later need to unlearn. Avoid fairy tales, half-truths, and circumlocutions. Honesty is the only policy. (The word truth in Judaism is *Emet*, containing the first, middle, and last letters of the Hebrew alphabet.)
6. *Do* share (but not legislate) your religious convictions as to FAITH, GOD, IMMORTALITY, PRAYER, AND DEATH. You are the pastor not an amateur psychiatrist. But have more concern for the welfare of the bereaved than for the "protection" of religious institutions.
7. *Do* spend time with responsive listening to the needs of mourners. The dedicated chaplain is a perceptive listener to the spoken word and

an astute discoverer of the nonverbal communication.

8. *Do* make referrals to other supportive people. There are times when even the best informed and well-intentioned chaplains are simply inadequate. Seeking further help from a therapist is not an admission of weakness but a demonstration of strength and love.

9. *Do* remember that the process of adjustment to death is longer than the funeral. The height of depression is six months after death! Make frequent visitations and encourage when possible widow-to-widower programs.

10. *Do* be human. It is not wrong to express your own emotions of grief—to shed a tear—physically and spiritually to touch a person in pain. Regardless of the theology employed, emotional tones are transmitted. Just remember the words of Thornton Wilder: “There is a land of the living and a land of the dead and the bridge is love—the only survival, the only meaning.”



THE CHAPLAIN'S MINISTRY TO DYING CHILDREN AND THEIR FAMILIES

Chaplain (LTC) James C. Jaeger, USAR

The wisest words I ever heard came from a colleague as he gave the graduation day benediction in a rather hot and crowded auditorium. His words have remained with me. He was telling us about ministering to people in need. He said: "You visit the lonely; minister to the sick; listen to the anguished; counsel the despondent; comfort the dying and guide the bereaved."¹ With this in mind we can try to promote some understanding of the four people involved, the child, the parents, the doctor and the chaplain; and then perhaps we can formulate better our own approach to a ministry that really must be very personal.

Ministry to the dying child is an area that could be easily neglected in clinical education for the Army chaplain. The Army chaplain, understandably, is oriented toward military personnel more so than military dependents. But the ministry to dependents and particularly to the dying child becomes very much a part of the chaplain's ministry in the military setting. Personal problems may arise for the chaplain who ministers to the dying child and to his or her family. The purpose of this paper, therefore, is to acquaint you with the terminal situations of children.

The content is largely directed toward those children who have a subacutely fatal disease, leukemia, oncology-solid tumors, metastatic malignancy. It also applies to the child who dies rather quickly after an acute accident, and to those children with cystic fibrosis, muscular dystrophy, and other diseases which are ultimately, but more slowly, fatal. I think the remarks will be best understood if we think in terms of the subacutely fatal diseases, those that will go on for several months or a year or two.

The child, when he has a fatal disease, feels very helpless.² From the child's point of view, he feels helpless because he is sick as the disease destroys his body. He also feels helpless because of the treatment. He is taking medications that make him feel bad, some that cause nausea and vomiting, and others that sap his strength and resistance. He feels helpless because of the impact of his parents' mourning, whose lives have been changed unalterably and very significantly. The child feels helpless because he cannot understand his parents' reactions. The child also feels helpless because parental omnipotence has been replaced by the physician;³ the pa-

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rents cannot take care of him any longer. The parents also feel helpless. They feel that the physician is failing because the child is getting weaker and the child is losing his confidence in the physician. So the parents look to the chaplain for help and encouragement. But the child may suffer more pain in terms of his fear of being alone.² He is now isolated as being *different*.⁴ He suffers the pain of loneliness because of adult reticence in discussing the disease. Upon asking some children what they're afraid of or why they take this medicine, they come up with the terrible answer, "I'm not supposed to know." It's a terribly frightened and lonely answer that they give. While some children obviously cannot know everything, they also cannot tolerate complete denial.² Death insight does exist in children beyond the age of nine, in some much earlier. They frequently perceive the prognosis, but they assume that the entire environment has conspired against them with a veil of silence. The environment says, "Please don't ask me about this. It's too terrible."⁵ Yet looking at the fantasies of children, the stories they tell, the pictures they draw, they have a fear of death,⁶ for death is unfamiliar to them.

This raises the question of what death means to the child. Let us look at the issue developmentally. When the child first becomes aware of his or her environment, the first person he comprehends as being outside of his own existence is his mother. The most immediate threat of death then is separation. Until the age of about five years, if we could ask a child what fears death has for him, he might reply that he is going to go away and will not be able to come back. He feels he will be taken away from his mother and father. Children at this age, moreover, will frequently deny that death is permanent.

As one becomes aware of his or her body (such an awareness takes shape, meaning, and texture between the ages of five and ten years), death assumes a different reality. It then becomes mutilation. When children fall and cut themselves, they rarely feel pain until they look down and see the blood, and that is when they feel pain because *we* have said, "That hurts." The cut itself often isn't painful, but the fact that blood is spilling out hurts. When the surface of a balloon is ruptured, the balloon is destroyed. Children see their bodies in a similar fashion and when surface integrity is interrupted, it is frightening. Death also represents a loss of body substance. Even as adults we retain these same fears, and same anxieties about death, the separation, and the mutilation.

As the child becomes older, he or she becomes aware of being affected by time. When one becomes ten-years old and later becomes an adult, one sees death as a different reality as a permanent biological consequence.

If this is what death means to the child, what are the needs of the child? Children before ten or so exist on a day to day basis. If they need relief from their anxieties about their disease, they need reassurance on a day to day basis. The three questions that a child would have, if he could formulate them, would be first, "Am I safe?", second, "Will a trusted person keep me from feeling pain, and from feeling helpless and alone?", and third, "Will the doctor make me feel all right again?" ⁷ And you, the chaplain, must add support here because your ministry will have a lasting effect to both the child and the parents.

Setting the child aside for a moment, let us talk about parents. When a fatal diagnosis is given to the parents, they go through a series of reactions. This basically is mourning, sometimes called premourning, or anticipatory grief, but the sadness in the mourning is there for the child who will not grow, the child whose life will not be fulfilled. There are generally four reactions: shock, denial, acceptance, and integration. Some of these exist very early; shock and denial do.

The most common reaction a parent has after hearing a terrible diagnosis is, "It's not true." Generally, however, there is a progression from denial into acceptance, then into integration of feelings, and then into getting back to the business of living one's life again. On the other hand, I have seen denial last five years, or as long as the disease.

Parents also have mechanisms for dealing with their reactive feelings. These are coping mechanisms, means of maintaining their integrity as people in the face of this overwhelming tragedy. They will become intellectual about it, "Can you give us something to read about sick kids?", "Can you help us?", "How long do we have?" If one can become intellectual, perhaps one can deny his feelings. Perhaps he or she need not go to pieces. This is a way of avoiding emotional aspects. It also becomes denial to say, "Is it really true?" If one asks the questions over and over again, maybe he is denying real answers; he is testing reality with repetitive questions.³ (Ask long enough and it will go away. Many of these questions only the doctor can answer.)

The parents will ask for other opinions, "Should we go to some center where they can handle this better?" "Is there some specialist in the field?" "We want the best for our child." Cries for help go out, but when you explain what you know about this illness there are great indications that they do not hear. Why? Because of the shock. The doctor must let time go by after presenting the diagnosis before trying to explain protocol and procedures. I am sure you have found yourself having to repeat yourself many times when giving encouragement to the parents of dying children. Give time to let parents get by the denial stage.

Another mechanism is anger.¹⁴ The parents have been told that their child is going to die, and they become angry; angry with the

doctor, angry with you, and angry with the ward personnel. But you have broad shoulders, and perhaps it's better they're angry with you than with the child or with themselves. A little later on they become irritable, expressing perhaps their own emotional pain thereby. Many is the family that is broken up, that I have seen separated during such illness. Ten years ago, one of three couples divorced after diagnosis; now it is one-half in my neck of the woods. An October, 1973, issue of the *New York Times* said that 75 percent develop psychosomatic complaints. This is a medical problem, but you can help. Perhaps you can get closer to the doctor through the parents and relate their difficulties to him.

One of the most important mechanisms of parents with such a diagnosis is guilt. "What did I do to cause this to happen to my child?" "What sin have I committed?" "How could I have prevented this?" Guilt, normally, serves a useful function but it does become overbearing when you feel guilty in this situation. You reach out to protect and to make up for all the things you haven't done. This, so often, becomes overprotection, and overindulgence. This is seen in many families. The "Disneyland Syndrome" develops where everything and anything is done for the child. I really don't know how to keep it from happening except maybe to temper it a little bit, but it does need to be tempered because it isn't good for the child, the parents, or the siblings. Doing things becomes necessary to reduce the parent's guilt rather than to be helpful to the patient.

As the child's whole existence is threatened, it becomes clear that the child is going to die, and that the life that the parents knew is being destroyed, parents begin to operate at a different ego level, seeking pleasure, or the absence of pain.⁶ Frequently when operating at this level, parents deny a diagnostic procedure because they're afraid it will hurt. They deny research procedures that might help someone else. This is happening more and more. They deny an autopsy because the child has suffered enough, or because they want him all there when he gets to heaven.

Another coping mechanism is hope, and I think this is the most important one for parents to have. Hope is powerful. Why should we expect these parents to give permission to do anything unless we can offer them hope? Without hope why do anything? We live with the hope that the child will be cured. This sustains parents through months and even years. It is the hope first, that a cure will be found, and the hope a little later on that another day like yesterday will be granted (a reasonably good day), and, finally, the hope that someone else will benefit from the experiences of this patient, their child. As this process continues, parents do attempt to accept the situation. This touches upon the chaplain's ministry to them. If temporal hope is

gone, then eternal hope is offered. Toward the end, as the child's health goes downhill, the physician withdraws medical support from the dying child and redirects his energies to other children in the hospital or to other children with this disease, or even toward others that he has ignored for so long. The doctors cope, too; and so do we chaplains.

These coping mechanisms are important because they allow the parents to retain some of their original integrity.³ They allow the parents to be effective, to participate in the terminal care of the child. They do need to be supported in this because they are the most important caretakers the child has; and perhaps encouragement is the best medicine we have to offer. The family is the world of the child, and only the family can really sustain the childhood joy of being alive. The chaplain, therefore, must support all family members with his encouragement.

The parents have further problems. The problem of answering the other children who are raising questions. What shall they tell these children? How can they tell them? Should they know? How much? There are, moreover, the well-meaning friends who expect that the parents keep their heads up, be hopeful, look for a cure, and demand at the same time that the parents be overwhelmed with grief.³ It's almost expected that they go around with long faces and no longer enjoy the things they might have laughed at before. The grandparents also go through the same denial the parents have; the diagnosis cannot be true. This places the parents in the uncomfortable position of having to defend the physician and his diagnosis.

Another participant in this process is the physician and he has some responsibilities. Death raises strong feelings within each of us,⁸ but life and death are woven together into the same fabric. Physicians go through similar stages as do the parents but with some differences. The denial of the physician is far more persistent in spite of the fact that he is the one who has a greater intellectual acceptance. We have all seen it. The terminally ill child is the one who doesn't get visited on morning rounds. This is the room that is the most difficult to enter, and those are the parents most difficult to meet in the hall. With the parents in the room, it's so easy to walk on by and see some other child who is going to get well and go home perfectly normal. This is the doctor's denial. With the terminally ill the physician who cares, becomes depressed and has his own feelings of guilt about the management of the case,⁶ and must also be ministered to. The chaplain has an important responsibility to minister to the doctors and nurses who have trouble coping.

For the chaplain there are two pitfalls. One is emotional overinvolvement and the subsequent loss of objectivity. The other pitfall,

perhaps the greater, is the avoidance of emotional involvement which leads to an underestimation of the child's awareness ⁸ and, more importantly, to a lack of availability of the chaplain. A good balance is required.

What are our responsibilities as chaplains to the dying and bereaved? We must become partners with the doctor in alleviating the pain and the emotional trauma. We must understand the reactions and defense mechanisms of the dying patient and his family. We must involve ourselves as early as possible and care for the emotional needs of the family while the physician cares for the medical needs of the patient. The military is something like the State of Washington that claims only 20 percent of the population churched, but 90 percent of the sick and their parents state a religious preference. They want all the help they can get. In order for the chaplain to help, he must first get involved and dare not expect to serve only those involved in his chapel program.

A hard question that keeps coming up is: Should the child know he is going to die? Frequently he does. It is easy for the child to discuss his fears of death with a chaplain who is a friend. More important than telling the child of the inevitable, the chaplain should understand the child's needs and questions, even those the child cannot formulate for himself.

The preschool child lives day to day and he fears separation. He needs to know what within his daily world separation from family will not occur; and this is a true feeling, well within the reality of the child. The parents will not permit that separation until finally he does die, and when he does die, he goes on somewhere else where pain will be gone and where there will be reunion. When the question comes up: "Be ready to give an answer of the hope that is within you," (I Peter 3:15); here is our function as chaplains, namely to instill hope.

The six to ten-year old child also has fears of separation, and, in addition, he sees death personified as one who will destroy his body. He needs to be assured day to day that the separation will not occur, that the body will be maintained, and that he will not be mutilated and the pain will be minimized. He needs to know that the doctor will not let him hurt any more than is necessary, and that nothing will be done that will not in the long run be better for him.

Then the more mature child, somewhere about ten-years of age, needs more than these daily reassurances; he has authentic death fears. The chaplain can help him or her express these in order to come to terms with the realities. You can wait for questions, but if you do, for every one that is asked there will be a hundred unformulated. One way to get into this is the use of a "third person" technique,⁹ and to spend some time with the child each day or each time you see him,

talking and getting to know him as a person. You can have him draw a picture of a person, or start a story about some person who is external to the two of you. This person will have a name and an age and daily life he goes through. Then the child can lead you, with a little direction on your part, through a history of the third person, and he can formulate his question, and you can help him formulate questions by asking: "Is he hurt?", "Does he get lonely?", "Is he afraid?" By using this imagined third person, you can both avoid commitment. The patient doesn't have to commit himself by asking, "Is it me that's going to die?" On the other hand, you can answer about this third person and be very open and honest with your comments. With younger children the third person could be a doll or a teddy bear.

If we try to understand dying children, we don't have to become angry when they become hostile toward us. We can also learn to anticipate problems, particularly parental guilt that leads to the tremendous overprotection and overindulgence of the child. If, moreover, the parents' guilt feelings can be explored directly and sympathetically, then the consequences of their feelings can be anticipated, discussed, and hopefully modified. We can help the parents become effective caretakers, to live as the child lives, which is day to day, and help them utilize their strengths as parents in sustaining their childhood joy of being alive. We can enable them to know the child as a person who has the security of dependable parents who will protect him from the external world, who will not overwhelm him with their own problems, and who will not overwhelm him with their grief. The family must still carry on after the death and our followup after the death may be the only one made.

We can all better understand the external parental problems with the siblings, with grandparents, and with friends. As we do this, we don't need to burden the parents with other guilts about the adequacy of the therapy. The physician can be competent, but doesn't have to acquiesce immediately to requests about referral centers. I feel we have a very total approach to offer as chaplains. We perhaps cannot offer as great an assurance as long-term survival or complete cure of leukemia, that is the doctor's job, but we can offer them something that is just as important, if not more important. This is our immediate availability as persons who care, and a God who loves them and has a plan for them.

You can be available to help the parents with their problems and provide an opportunity for answering their questions. This time does not necessarily have to come at the time of diagnosis because parents need time to react to grief. But our availability will provide them with a sounding board for their expressions of "fear, anger, guilt, sadness" (FAGS Syndrome),³ and for their questions.

As for the parents and grandparents, it can be very helpful to call upon their clergy to participate in the care. If you are going to call other clergy, they should be included at the beginning. You should not ask them to be the harbinger of death and call upon them only at the time of the terminal event, because they can supply emotional support in caring for these people throughout the entire course.¹¹ Above all, get involved yourself. Here the chaplain can have a real ministry. He can visit the lonely, minister to the dying, console the despondent, comfort the dying and guide the bereaved. Such a total ministry is a challenge to all of us.

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..... THEREFORE CHOOSE LIFE

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Sailors on the ancient four-masted schooners, the cutters, and brigantines used to gather about the sea trunk of a washed-over-the-rail buddy to sing, "Fourteen men on a dead man's chest, Yo, ho, ho, and a bottle of rum." Death was a grim reality in the context of a life threatened by heavy seas, Barbary pirates, and tubercular ladies at the ports of call. So they would get drunk and sing to purge their emotions and steel themselves against another bout.

Today when we see fourteen persons, more or less, approach the aged and dying person with a "magical" bottle containing the wonders of modern medicine, we wonder if we have made any advance on our perspectives concerning death. What is the seemingly frantic effort all about? Is it a response of the medical team to the genuine fears and anxieties of those who face death? Perhaps, instead, it is a reaction to their own worries and concerns which holds them back from making rational and humane choices. In any event, it is proper for each one who is involved with aging persons to ask himself or herself just what is going on in respect to the attitudes, feelings, and behaviors of all concerned.

The clergyperson working with the aging will seek for answers because he or she knows from scripture and from events that there is a constant call for decision. Within this call is the clear indication that living itself is a deciding.¹ Significant awareness of *being* comes when one realizes that he or she must choose existence. That perception comes most vividly, of course, in a time of despair when one contemplates the taking of his or her own life and then determines not to. Facing the option squarely and choosing life rather than death enables the person to affirm *being*. Thus it is that when one is conscious of a freedom to die, that one is also aware of the impact of his or her own choosing to live.

For this reason it seems clear that the stance of helping professionals should be on the side of assisting those who are advanced in years as they make their choice to live. This is true especially when working with those with chronic and, perhaps, painful illness. Their deaths may be near at hand. When the elderly are treated with a disrespect that edges on contempt, when they are cast in the role of those who are too senile to make contributions of value to the community, when they

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are shunted off from the mainstream of events and are forced to feel the sting of loneliness and alienation, then the ministering person who does not object has become too callow to do his or her job. Such a one is not really concerned. Such a one neither ministers nor helps. In the context of such observations the Jewish writer, Norman Lamm, says that a person's ethical and spiritual achievements are noticed most clearly as one observes his or her approach to death.²

It is of prime importance that those who work with aging persons understand death. The thoughts they have here have a profound effect on their manner of relating and on the consequent influence they exert. If they are afraid of dying they will convey this apprehension especially to the aged person who is terminally ill. They may even avoid such a one and make up plausible excuses to delay visits. In doing this they contribute to the aged person's premature death. In the context of a careful clinical study Robert Kastenbaum and Ruth Aisenberg concluded that the isolated older person is the one most likely to die at a time much earlier than the prognosis would lead the physician to expect. The solitary nature of that one's existence may well be the factor in the timing of his or her death.³

Members of the helping professions are often awkward as they try to relate to older persons. Frequently this is the result of the mistaken notion that the elderly are largely concerned about matters pertaining to death. Thus one who would otherwise minister well is hampered by some half-remembered feeling of guilt in respect to a death wish fleetingly held toward one of his or her own parents. Still another may be exasperated because of an inability to give help which shows an immediate practical consequence.⁴ Anxiety builds within the ministering one and within the "field" that exists between him or her and the older person. Each one departs from the encounter feeling inadequate. Both the elderly one and the ministering person may then harden themselves so as to feel these emotions no longer.

Many decisions are made in the context of treating those who are aged and ill. The factors involved in the making of choice in respect to those who are dying or presumed dying are complex. They entail the values established within society, the laws of the community which serve as guides, the total impact of the patient's lifestyle, and the stress occasioned by the interplay of the sick person's physical/mental disability and his or her social dislocation. Also involved are the lifestyles, beliefs, and attitudes of persons on the healing team.⁵

With wholesome attitudes that do not include fear and a threat to their own persons, members of the medical team, including the clergyperson, can assist the chronically sick or terminally ill aged person so that he or she can retain courage and self-identity to the end. They will stand by to mitigate against the feeling of awful isolation that

comes when one faces the dying hour. Ideally, they use their own stances towards death so as to support the positive feelings of the patient in a therapeutic way. Such helping professionals realize the dangers of their own fallibility, but are not overcome by a sense of failure and disillusionment. As they work with the elderly sick person they do not hold out a false expectation of life. Yet, they do instill hope. The ministering one may come to realize, as did Albert Camus, that if one is capable of limiting hope so that it is not a denial of what is, and if hope does not end in one's resigning the self so as to make no effort to revolt against the intolerable, then that hope can be a benefit to the one who has it.⁶

A person's thoughts concerning death have a significant bearing on his or her understanding of life. It is in death that the meaning of life is revealed. Under the all-surrounding threat of death each situation of suffering becomes the occasion or the opportunity to find the meaning of existence itself.⁷ When seeking to understand the meaning of life one must take into account his or her own terminality, temporality, and finite state.

Each one working with the persons who are advanced in age needs to come to an understanding of life and death which is acceptable to him or her. Yet even as we state this we must emphasize our agreement with Elisabeth Kubler-Ross who speaks of both the aged and the young as coping with death and the dying process in the same way. She does not make age distinctions.⁸ Since we concur, we will generalize our affirmation a bit wider: *each one seeking to minister to another must work out personally satisfying attitudes towards death.*

For some persons death is a terrible enemy. Perhaps to all it appears thus at times. Conceptions centering on pain, sickness, and death fill us all with disquieting emotions in that each of them threatens our individual preservation. Death seems to stand as a symbol of defeat. It is a mysterious evil that comes to separate us from companions and all delights.⁹ This feeling overwhelms us even when we would rather make a strong show of courage.

In the August, 1972, issue of the *American Journal of Psychiatry*, doctors Kimsey, Roberts, and Logan reported their investigation of the degree to which death and dying is a central issue for the aged. They also wanted to know how the aged deal with such concerns. Early in their investigation they discovered that their question was meaningless. It made the assumption that the aged are homogeneous. Such is not the case. They found that they had to differentiate among the aged. As they did so they determined that the healthy-aged person is no more concerned with dying than the healthy-younger person. They also determined that the chronically sick and physically deteriorated

individual of whatever age responded in similar manners to the threat of dying.¹⁰

Many persons, young and old, see death as something of which to be ashamed. They may interpret it as coming solely as the result of sin. This is what some theologians mean when they say that it is not in the nature of things for people to die.¹¹ Further, a large number of individuals consider that death is something of which to be ashamed in that it disfigures a person. The severe physical effects of many illnesses are such that even the closest friends, spouses, and children hesitate to enter the patient's room. Wan, emaciated, covered with scars and emitting fetid smells, the patient conscious of his or her condition feels apologetic about the sickness. "Why should I impose myself thus on those I love?" the anguished one asks.

Such shame, inwardly directed anger, guilt, and despair lie as the partial base of the noted attempts to put "death with dignity" legislation into the codes of many States. The individual contemplating such an unpleasant death may desire to make out a "living will" which will direct the physician not to take heroic and extraordinary measures to conserve his or her life. Yet, many others—even those who think of death as an enemy—take the view that being heroic is not to be valued negatively. They do not emulate the anti-hero of current literature. In fact, they hold to the belief that if one refuses to be beaten he or she may be in for some pleasant surprises.

The struggle one makes in the process of choosing life over death is often confused with denial. Kimsey, Roberts, and Logan, whom we have mentioned, gave Thematic Apperception Tests to those they had interviewed directly about their concerns with dying. In the direct interviews, the aged reported little fear of death. The TAT stories, however, revealed interesting variations. Those who were well and autonomous used less denial and displayed more appropriate emotion than did those who were sick and dependent. These researchers concluded that aging as such does not lead people to regress psychologically. It occurs when deterioration and despondency force them to disaffirm their condition. Those who are reasonably well and capable of meeting their own needs do not give evidence to support the assumption that they have resorted to a denial of death fears. Their fears are as open or as concealed as are those of persons who are younger.¹²

Denial of the inevitability of one's own death leads to many obvious symptoms. These kinds of things show up in those well advanced in years, but they are not limited to the aged. Rollo May indicates that these things result when one represses his or her awareness of personal death: 1) A lack of zest; 2) A listlessness in which one does not experience himself or herself as vital and alive; 3) A depressed state in which the individual sees himself or herself as some kind of creature of

mechanical action; 4) An inability to solve problems or to face them squarely; and 5) Little or no creative effort. The obvious help that the ministering professional gives at this point centers about assisting the person to consider the unavoidable aspects of his or her own dying. Such a death awareness sets one free to bring meaning, love, pleasure, and creative activity into the time available.¹³ *One chooses to live through choosing to face the reality of death.*

Death awareness can dampen the human spirit when it progresses to a nameless dread. In such a case, avoidance of life-threatening experiences may become the chief human value. Undue caution and a careful dodging of circumstances which might be harmful to one's health often become the behavioral manifestations of aged and young alike who overtly fear death. One needs to fight against suffering and to avoid those risks which hold out no promise for the realization of significant values. Even so, the ministering one must be alert to the dread which may lie at the base of various individuals' extreme caution.

Many a modern person has something other than a simple fear. Beyond life many conceive of there being nothing at all. They are unlike Hamlet who was fearful of what lies beyond death. Rather they think of death as a separation from *being*. Instead of fear they have anxiety. Psychological tests given in recent years to those well advanced in years indicate that these older persons, even though they do not claim to fear death, do have at least a mild amount of anxiety concerning the prospect of their own ceasing to exist. Much of this evidence is conflictual and it does not appear a firm conclusion that death anxieties are at a higher level among the aged than among others.¹⁴

Confronted with even a transient thought of death one does become uneasy about the contingencies of existence and asks such an elemental question as: Why do I now live as the person I am under these particular circumstances? One notes the emptiness of many experiences and puzzles over the meaning of life and the values of society. Feeling either vaguely or particularly guilty one senses the appropriateness of condemnation.¹⁵ One finds welling up from within his or her self that which Kierkegaard calls "angst": an anxiety characterized by a foreboding dread. In spite of the fact that one faces a concrete situation that can be analysed and understood, one is filled with a nonspecific fear that relates to nothing definite. One is in a state of anxiety because of his or her expectation of *non-being*—a ceasing to exist—a passing into nothingness.

In spite of the anxiety based on threats to one's *being*, a person cannot assert his or her self apart from the making of decisions. As Martin Heidegger has stated, all-surrounding death is the chief threat

to self-affirmation which is necessary for existence. Yet, one must not retreat from considering the fact of death which leads to the anxiety. In doing so one moves back from an authentic awareness of self. One must, therefore, take into himself or herself the actual threat of death (*non-being*) in order to experience the self in a valid manner. A failure to do this paradoxically is a choice leading to *non-being*. A lack of authentic self-awareness is characterized by a curious fascination with the world, idle talk, and ambiguity.¹⁶ It does not appear that older people exhibit these symptoms more markedly than do younger persons. There is no evidence to support the stereotype that the aged tend to view death as an enemy to a degree more significant than do others.

In contrast to the view of death as an enemy is that which identifies death as a welcome friend. To this thought the ancient philosophers gave ample testimony. Socrates expressed the idea that no evil can happen to a good man either in life or in death. It is impossible that anyone who thinks aright can regard death as an evil.¹⁷ Epictitus declared that death is not a terrifying event, only a death of shame.¹⁸ Modern theologians such as Reinhold Niebuhr have concluded that death as an end (*finis*) is no threat when one has achieved his or her purpose ("end" in the sense of *telos*).¹⁹

The "welcome friend" notion expresses a variety of ideas concerning death. It may well be the greatest good rather than a fearsome evil. In his classic essay on old age Cicero spoke of death as the safe harbor at the end of a long and tedious voyage.²⁰ Still yet, in medical terms, it is the ultimate cure for all diseases in that it brings to an end our physical existence as we know it. Being this kind of thing it is pictured by many as an object of praise. Perhaps the most clear expression of this way of viewing the situation is found in Walt Whitman's poem, "When Lilacs Last in the Dooryard Bloom'd."²¹ Life may be filled with joy, love, and curious objects rather than abject suffering, but even so death is the appropriate subject of praise.

Poetic notions abound when one considers death as a welcome friend. One wants to die with the boots on, sitting in the saddle astride a stallion strolling into the sunset. Another wants to be like Lao-Tze the founder of Taoism, who, in his extreme old age, resigned from his government post and simply rode in his two-wheeled ox cart through the western pass in the wall of China, and was gone. A more prosaic research in gerontology reveals that dying elderly patients tend to face death with considerable equanimity. Seventy percent of those over sixty who were interviewed by Jean Roberts in a careful study have showed a larger acceptance of dying than have those who are younger. In fact, fourteen percent of them saw death as either a

happy reunion with the Lord or as that release from burdens which is welcome.²²

A present-day theologian, Leslie Weatherhead, accepts the harsh fact of death. He emphasizes, however, that death does not defeat God in his intention for anyone. He holds that God does not desire the death and whatever suffering it may entail. Death comes from people's misuse of free will, mass ignorance or from folly and sin. Therefore, when the medical team goes about its task it works with God to overcome these things and their effects. When the effort fails and an individual dies, God is not defeated. This has not been God's intent, but even so he is omnipotent in the face of it. Weatherhead says that in our suffering unto death we are to turn even this event to our own and the world's highest good.²³

Even though one can not agree with all that Weatherhead says in this respect, one can appreciate that portion of his reason which finds its focus in the assumption that death does not end in annihilation of the person. There must be some components of the person which survive biological death. The forces of power associated with the physical-mental aspects of a human being surely have a dimension of reality that persists beyond the limiting three dimensions that we normally perceive. The reality of the fourth dimension of space-time, which is not an object of direct perception, has been established firmly. The fifth dimension, if such there is, is undergoing serious study. There is much more concerning human beings and the world in which they live that no one observes. We agree with the philosopher Carl Jaspers who places large stress on his understanding that there is always more to human beings than that which can be known.²⁴ The most significant factors are beyond our present comprehension. It is not unreasonable to conclude that death is incapable of being an end to these things.

Death can be viewed as a welcome friend even by those who are vigorous in their choosing of life. Blaise Pascal is closer to the mainstream of Christian thought than Weatherhead when he states his belief that death comes under the providence of God. By this he means that death is caused solely by the decree of the Lord. It is not that which comes by chance, nor the fatal necessity of nature, nor yet through the play of the elements. Far from being an accident or dire result of sin, it comes from the innermost part of the will of God. Of itself it is horrible. One does not choose it. Even so, in that God through Christ has transformed it, one may be accepting of death as that which is ultimately benignant, holy, and a source of joy.²⁵

Just as Pascal and Weatherhead are not in agreement concerning the place of the will and providence of God and can still view death as that which is no final enemy, so also can one hold a positive attitude

toward death apart from agreeing to their significant belief that there is something immortal about the human person. I believe that Christ gives abundant and eternal life to those who trust in him, but the Jewish theologian, Will Herberg also takes a positive attitude towards death while saying that one's assertion of immortality is a delusion which is a denial of death and its ultimate triumph. This delusion is a claim for self-sufficiency that lies at the heart of sin.²⁶ Notwithstanding, one can seek to live life to the full even as one declines to view death with adverse feelings.

Two questions emerge from what we have said. If one sees death as a welcome friend rather than an enemy to be defeated at all costs, what effect does this have on the decisions that he or she must make in those times when the dying process seems to have started? Also, what effect does this view have on the activity of those who minister to that one either as health professionals or as clergy? These questions imply that we know something which in fact we do not. We really do not know when the process starts for anyone. More fundamentally, we have only a most provisional notion of what death is. There are, actually, no experts on dying and death. Since this is so, we can make answers only in a limited way.

A seriously sick person may express a wish to die. The reasons for this are complex even when some simple and rather obvious circumstances seem to explain this desire. Yet, whatever the reasons, researchers have established the fact through the various bits of clinical evidence that aged patients with a persisting death-seeking mood do change their minds and feeling states. When the ones caring for such a person provide appropriate comfort and stimulating contacts, that individual frequently expresses the contrary choice of holding on to life. Even the suicidal person may be grateful at a later time that his or her feelings were respected even in those moments when they were not obeyed.²⁷

The helping professionals must strive to create a climate in which one is encouraged to choose life rather than death. Michael B. Miller has analyzed the decision-making process as it relates to sick persons who are advanced in years. He concludes that each institution in which they are treated must be committed to patient survival and restitution. If that institution and the people working in it are to be a part of the community then they must put up an unrelenting effort to preserve and maintain life. Persons working in these places can not participate in a process in which some patients' expressions of death wishes are honored so that they are selected for death while they labor at the same time to perpetuate the lives of those who say they choose to live. Such an ambiguous situation would undermine the staff morale in that it would challenge to the roots the fabric of moral-

ity of all who are brought up in a culture influenced so profoundly by the Judeo-Christian tradition.²⁸

This commitment of assisting the aged to choose life is exactly the same as that made to any age group. For the aged, though, it means that some particularly pressing needs be met. The most obvious need, be they sick or well, is that of transportation. If they are to be in the mood to choose life they must have mobility sufficient to get to hospital clinics or doctors' offices. They must be able to travel enough to encounter a variety of sensory experiences and to have fun. Also, they must have nutritional needs met. The program "Meals on Wheels" is not just a fad. For many it is what tips the scales in favor of life. The aged especially require meaningful activity. For one person this may involve the making of an octopus of yarn or the putting together of one of those jig-saw puzzles with the giant interlocking pieces. Yet, another person in markedly similar circumstances may demand that his or her occupation be more "gainful."

Every elderly one requires the opportunity to stand out as a unique individual. One can do this by not being forced to conform to stereotyped group norms. Nothing hastens a retreat into *non-being* so rapidly as the descent into the formless mass categorized as "humanity." No human is simply a portion of a species. If that were so, then no person could have a claim to his or her own life.²⁹ Each one must be given options which will enable that one to choose to be his or her own person. Faced with many options, one does not encounter in such a demanding manner that ultimate choice of living or dying. One can face the alternatives, choose life, and go on to live. The one who would assist can do so by helping each other person to maintain a sense of involvement, an awareness of his or her own autonomy, and a love for self which permits an understanding of one's own worth.³⁰ Then all can accept death when it comes without fear.

1. Shinn, Roger, *The Restless Adventure* (New York: Charles Scribner's Sons. 1968) p. 57.
2. The Good Society, (New York: Viking Press, 1974) p. 132.
3. "Premature Death and Self-Injurious Behavior in Old Age," *Geriatrics*, 26 (July 1971) p. 72.
4. Felfel, Herman, "Attitudes towards Death in Some Normal and Mentally Ill Populations," *The Meaning of Death*, Herman Feifel, editor, (New York: McGraw-Hill Paperback Editor, (New York: McGraw-Hill Paperback Edition, 1965) p. 122.
5. Miller, Michael B., "Decision-Making in the Death Process of the Ill Aged," *Geriatrics*, 26 (May 1971) p. 115.

6. Compare his "The Myth of Sisyphus" with his "Summer in Algiers" both of which are printed in *The Myth of Sisyphus*, (New York: Vintage Books, 1955) pp. 88-91 and 104-113. See also *The Plague* (New York: Vintage Books, 1948) p. 243.
7. Frankl, Viktor, *Man's Search for Meaning* (New York: Washington Square Press, 1963), also *Psychotherapy and Existentialism*, (New York: Washington Square Press, 1967).
8. Kubler-Ross, Elisabeth, *On Death and Dying* (New York: Macmillan Co., 1969).
9. Anonymous, *Stories from the Thousand and One Nights*, translated by Edward W. Lane. The Harvard Classics, Vol XVI. (New York: P.F. Collier and Son, 1909) p. 443.
10. "Death, Dying and Denial in the Aged," *American Journal of Psychiatry*, 129 (August 1972) p. 164.
11. Thieliicke, Helmut, *Christ and the Meaning of Life* (New York: Harper and Row, 1962) p. 37.
12. Kimsey, et al, *op. cit.* pp. 161-164
13. "Existentialism, Psychotherapy, and the Problem of Death," in *The Restless Adventure* edited by Roger Shinn (New York: Charles Scribner's Sons, 1968) p. 195.
14. Roberts, Jean L., et al., "How Aged in Nursing Homes View Dying and Death," *Geriatrics*, 25 (April 1970). pp. 115-119. Kastenbaum, Robert, "The Mental Life of Dying Geriatric Patients," *The Gerontologist*, 7 (June 1967). p. 100.
15. Tillich, Paul, *The Courage to Be* (New Haven: Yale University Press, 1952) pp. 51-54.
16. Heidegger, Martin, *Being and Time* (New York: Harper and Row, 1962) pp. 219-220.
 Vide also
 Martin, Douglas, "An Existential Approach to Death," *Journal of Thanatology*, Vol 3, #2, 1975. pp. 105-111.
17. Plato "Apology," in *Great Dialogues of Plato* (New York: Mentor Book, 1956) pp. 445-446.
18. Epictetus, *The Golden Sayings of Epictetus*, The Harvard Classics, Vol II. (New York: P.F. Collier and Son, 1909) p. 135.
19. *The Nature and Destiny of Man* (New York: Charles Scribner's Sons, 1941) Vol II. pp. 287-288.
20. Cicero, Marcus T., *On Old Age*. The Harvard Classics, Vol IX. (New York: P.F. Collier and Son, 1905) p. 71.
21. Whitman Walt, "When Lilacs Last in the Dooryard Bloom'd," *Writers of the Western World*, edited by Addison Hibbard (New York: Houghton Mifflin Co., 1941) p. 987.
22. Roberts, *op. cit.* pp. 115 and 118.
23. *Salute to a Sufferer* (Nashville: Abingdon Press, 1962) pp. 87-89.

24. *Reason and Existenz* (New York: Noonday Press, 1955) pp. 70 and 75.
25. *Letters*. Harvard Classics, Vol XLVII. (New York, P.F. Collier and Son, 1909) p. 338.
26. "Biblical Faith and Natural Religion," *Theology Today*, XI, 4 (January 1955). pp. 460-467.
27. Kastenbaum and Aisenberg, *op. cit.* p. 81.
28. Miller, *op. cit.* pp. 115-116.
29. Teilhard de Chardin, Pierre, *The Phenomenon of Man* (New York: Harper Torchbook, 1961) p. 173.
30. Kimsey, Roberts, and Logan, *op. cit.* p. 165

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A SOCIOLOGY OF DEATH AND DYING

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The topic of this issue of the *Military Chaplains' Review* implies an awareness of the fact that death is not only an event (death), but a process (dying). This process is more than a simple biological process. Death and the process of dying is a very appropriate topic for investigation by social psychologists, not only because of the many attitudes held about death in our culture, but also because of the process of dying itself in human social behavior.¹

This paper will examine, from a social psychological perspective, the pattern of human social behavior called dying. In what ways are our patterns of dying influenced by our attitudes toward death? Do people die socially and psychologically before they die biologically? Death can be described as involving at least four interrelated dimensions. *Human dying is a spiritual, social, and psychological process, as well as a biological process.*

It should be noted that our contemporary United States culture places greatest emphasis upon the biological aspect of human life. This is reflected in the fact that failing to maintain mechanical life-support devices for a hopelessly comatose person is considered a more serious crime than the inflicting of grave brain injury to him which rendered him comatose in the first place.

Our attitudes toward death as well as our patterns of behavior when dying are learned. Some human learning occurs as the result of direct experience. Obviously our attitudes regarding death and our patterns of behavior when dying could not have been learned through trial-and-error direct experience. Like most human attitudes and patterns of behavior, they are learned indirectly from others through our interactions with them. Other persons share with us their experiences, beliefs, and fears, as well as appropriate patterns of behavior in their conversations and customary activities with us. Through this process, we develop attitudes regarding many things about which we have had no direct experience. Attitudes and patterns of behavior tend to be culturally determined and widely shared within a given society.

¹ Glenn M. Vernon, *Sociology of Death: An Analysis of Death-Related Behavior* (New York: The Ronald Press Company, 1970) pp. 92-127.

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One important attitude about death widely held in our society is a crippling fear of death—fear of even facing the thought of death.² As a result, a powerful taboo exists prohibiting references to death, or the discussion of death as a topic. Death is considered in the same conversational category as sex was a generation ago—not a proper subject for extensive conversation.³

Glaser and Strauss conducted a study in which they investigated when and under what circumstances a person suffering from a terminal illness becomes aware of his impending death. They found that physicians rarely imparted this information directly to their clients. Nurses and other hospital professionals, such as hospital chaplains, tend to go along with the deception. Even the family and friends of the terminal patient are relieved and comforted by the fact that “he doesn’t know.” The usual way that the individual learns of his imminent death is through indicators such as his own progressive physical deterioration, nurses who are more concerned with his comfort than providing treatment designed to lead to his eventual recovery, or hints dropped consciously or unconsciously by relatives or professionals.⁴ Even when he realizes the gravity of his condition, the terminal patient often goes along with the pretense. The result of this prevailing practice is that many persons are allowed to die while games of deceit and pretense are being carried on by those who could help them prepare to die. The dying individual needs more than simply being made as comfortable as possible. A reevaluation of the prevailing practice of not informing a terminal patient of his condition needs to be made.

The Bible describes man as endowed with a body, soul, and spirit. The socialized human being is more than simply a biological organism that reacts to his environment. The very fact that man can be aware of his own death and determine, to some extent at least, the circumstances in which he dies is due to the fact that he has a self. This means that the human being is capable of seeing himself as an object and acting over against himself. According to George Herbert Mead, the concept of self is developed through the interaction process. It consists in the perception by the individual of how others see him. The self-concept is a psychological process that is socially derived and maintained.⁵ Human dying can, therefore, be described as a spiritual, biological, psychological, or social process.

² Robert Kastenbaum and Ruth Aisenberg, *The Psychology of Death* (New York: Springer Publishing Co., Inc., 1972) pp. 40–112.

³ Vernon. *op. cit.*, p. 10.

⁴ Barney G. Glaser and Anselm L. Strauss, *Awareness of Dying* (Chicago: Aldine Publishing Co., 1965).

⁵ George H. Mead, *Mind, Self and Society from the Standpoint of a Social Behaviorist* (Chicago: The University of Chicago Press, 1934).

SPIRITUAL DYING

The tenets of many religious traditions include the concept of spiritual death to describe an individual separated or alienated from God. An important aspect of the ministry of the chaplain to the dying involves dealing with the spiritual life and health of the dying person.

BIOLOGICAL DYING

Biological death occurs when the brain, heart, and other vital human organs cease to function. This may occur suddenly as the result of a massive injury, heart attack or cerebral hemorrhage. Or biological dying may occur gradually as the result of a progressive debilitating disease such as bone cancer.

In another sense we can say that biological dying is occurring continuously. The cells of our body are created, grow, and die, to be replaced by new and similar, and sometimes different cells. Some cells on the other hand, like the cells of the nervous system, are not regenerated, and must last us a lifetime. Several thousand brain cells die every day not to be replaced.⁶ The process of biological dying also occurs as the result of fatty, fibrotic and pigment degenerations. Fatty deposits, called cholesterol, slowly reduce the flow of blood in the cardiovascular system gradually producing the condition popularly called hardening of the arteries. As we grow older, muscular tissue is gradually replaced by connective tissue that is neither as versatile or serviceable as the original cells. Within the cells of our body there is a gradual build-up of pigment granules that can impair normal cellular operation, and even lead to cellular death eventually.⁷

Each human being has a relatively fixed timetable of maximum biological life determined by his genes inherited from his parents, as well as environmental factors such as nutrition, exposure to cancer causing agents, and diseases suffered. If death does not occur earlier as the result of disease or injury, eventually a massive breakdown of a number of vital organs occurs resulting in what is popularly called death by old age.⁸

PSYCHOLOGICAL DYING

The psychological process of dying is at least as important as the biological. We can say psychological death has occurred when an in-

⁶ Wilma Donahue and Clark Tibbitts (eds.) *The New Frontiers of Aging* (Ann Arbor: University of Michigan Press, 1957) p. 130.

⁷ Marvin R. Koller, *Social Gerontology* (New York: Random House, 1968) pp. 42f.

⁸ Bernice L. Neugarten, "The Future and The Young-Old," *The Gerontologist*, Vol. 15, No. 1, Part II (February, 1975) pp. 4-9.

dividual has become irreversibly comatose. Mental processes have diminished to such an extent that he no longer is aware of his surroundings and no longer able to carry on rational thought processes.

One process of psychological dying involves a gradual diminishment of reality-oriented rational thought processes, as well as a loss of awareness of self and others. This process is sometimes called the onset of senility or senile psychosis. Senile psychosis may be organic or functional—that is, it may be brought on by biological or socio-psychological factors. Organic senile psychosis may result from brain deterioration resulting from hardening of the arteries diminishing the flow of blood to the brain. The degeneration or failure of other organs, as well as loss of muscle function, may contribute to the psychological dying process since the gradual loss of the ability to see, hear, speak, and get around reduces sensory input, mental stimulation, and reality orientation.

Functional senile psychosis also involves a diminishment of mental activity and interest in social activity. It is not however, brought about by a physiological condition. Rather, it may result from a trauma which drastically alters the social world or life style of the individual. The psychological trauma may include one or more of the following: retirement; loss of spouse; incapacitation due to illness or injury; change of residence; loss of separate domicile; death of friends; or subordination to adult offspring.

Another form of psychological dying is severe depression. The individual loses interest in life, sees himself as worthless, becomes apathetic and melancholy, has little appetite for food, and has little interest in interacting with others. Depression is often a prelude to biological death. In a study of twenty-five Spanish-American War veterans conducted in 1967, the veterans were classified as depressed or not depressed. A year later it was found that three of the four veterans classified as depressed had died, and four of the five suspected of depression had died, while only one of the sixteen classified as not depressed had died.⁹

The causes of depression are still unclear although the symptoms of depression are often manifested when one or more of the psychological traumas described above are experienced. Depression is a condition often experienced by elderly patients in nursing homes, particularly when the patient has been placed there against his will. Persons suffering from senile psychosis sometimes also suffer from depression

⁹ Arthur W. McMahon Jr. and Paul J. Rhudick, "Reminiscing in the Aged: An Adaptational Response", *Psychodynamic Studies on Aging*, Sidney Levin and Ralph J. Kanaha, eds. (New York: International Universities Press, Inc., 1967) pp. 64-78.

so severe that they refuse to eat or drink, thereby bringing on their own biological death.¹⁰

SOCIAL DYING

The extreme form of social death is total withdrawal from the world of reality, when an individual no longer responds to the persons in his social environment. This extreme form of psychosis requires hospitalization. Social dying seldom progresses to this stage however.

Cumming and Henry describe as a normal part of the aging process a form of social dying which they call disengagement. Disengagement is the gradual mutual withdrawal between an aging person and his social world. This process may be initiated by either society or the individual. It involves a progressing decrease in interaction between the aging person and others in the social systems he belongs to. The process is seen to be mutually beneficial in that it allows a physically weakening individual to gradually reduce his activities in an orderly and socially acceptable fashion, and also makes room in the various social systems for maturing young adults.¹¹ The norms of society include expectations of appropriate times for retirement and other forms of disengagement. The individual usually complies with these norms. If he perceives strong expectations to disengage, then he will be likely to accommodate to these expectations and disengage. However, if the expectations of others which he perceives reinforce his morale and offer encouragement to role involvement, the individual is likely to conform to these expectations, and the process of social dying is delayed.

Cross-cultural studies indicate that disengagement and role withdrawal patterns vary greatly from culture to culture. In a youth-oriented culture there may be strong pressures by the younger group to exclude the older group from effective participation in certain roles such as work or politics. The peer group expectations as perceived for example by individuals in homes for the aged, may have the same result. On the other hand, in occupational subcultures in certain communities, the expectations of role involvement of the aged remain high. Opportunities for active role involvement are available. In these, disengagement is less pronounced.¹²

Where disengagement theorists see social dying in the form of role loss and reduction in social interaction as natural and even desirable, other sociologists view this process as undesirable and seek to halt it or

¹⁰ Mark and Dan Jury, "Gramp", *Psychology Today*, Vol. 9, No. 9 (February, 1975) pp. 4-9.

¹¹ Elaine Cumming and William Henry, *Growing Old* (New York: Basic Books, 1961).

¹² Robert J. Havighurst et al., *Adjustment to Retirement: A Cross-National Study* (New York: Humanities Press, 1969) pp. 35-48.

compensate for it. For example, sociologists writing from an interactionist perspective hold that role playing behavior is indispensable in the development and maintenance of human personality. Through the process called "symbolic interaction" with other people in meaningful situations, human personality is integrated and reality-oriented. On the basis of his conceptions of how others see him, the individual also develops and maintains his concept of self. The process of social dying may involve many of the following role losses imposed by society: (1) retirement from full-time employment, (2) relinquishment of housework by women, (3) withdrawal or exclusion from active community and organizational leadership, (4) death of mate resulting in spouse role loss, (5) loss of separate domicile, (6) loss of goals and ambitions, (7) loss of parent role, (8) loss of opportunity to interact with anyone but old people.¹³

Burgess describes the condition of the aged person in society as one of rolelessness. He sees the individual upon retirement in a transitional period where he has lost many of his most important roles. In addition, he no longer feels useful and worthwhile and has suffered a decline in both economic and social status.¹⁴ Children often are unable or unwilling to care for their elderly parents or even visit them regularly. Grandchildren and old friends become relative strangers. Social contacts are infrequent and minimal. There is a growing detachment from reality. The retiree slowly dies socially, then psychologically, and finally biologically.

The loss of two roles are particularly critical in the process of social dying—the work role and the role of spouse. Retirement and widowhood represent the points at which the central tasks of men and women are terminated. Retirement is not as important a factor for women because the work role is usually not as central to their lives. Women often work simply to augment income or to fill up time. For men, on the other hand, work is the central activity of their lives. Their work serves as an index of prestige in the community, the measure of success, and in a real sense, an expression of the whole man.¹⁵ We can expect the loss of the work role to become comparatively more severe as the result of a shift to careerism among women in our society.

Through his study, Havighurst found that the reaction to the work role loss is dependant upon the type of work engaged in. Steel workers, representing those who are engaged in manual labor, looked forward to retirement and seldom sought a replacement for the lost

¹³ Bernard S. Phillips, "A Role Theory Approach to Adjustment in Old Age", *American Sociological Review* XXIII (April, 1957) pp. 212-217.

¹⁴ Ernest W. Burgess, *Aging in Western Society* (Chicago: University of Chicago Press, 1960) pp. 5-30.

¹⁵ Erdman O. Palmore, "Differences in the Retirement Patterns of Men and Women", *The Gerontologist* V (March, 1965) pp. 4-8.

work role. They tended to disengage from this aspect of their life completely. School teachers, representing those in middle-class type work roles, abandoned the work role very gradually. If they involuntarily retired, they usually found replacements for the lost work role.¹⁶

Widowhood, although generally less severe for women than for men, is a more important factor for women simply because there are many more widows than widowers. Because the man is often left helpless when his housekeeper has been taken, the transition to widowhood is more severe for men than for women. For women, marriage becomes less functional as the life-span progresses. Once sexuality becomes irrelevant, a brother or sister can often serve as a companion as satisfactorily as a husband. After retirement, the economic dependence of the wife upon her husband is also lessened. In light of the severe impact of the spouse and work role losses upon males in our society, it may be an act of mercy by a gracious God that he usually allows the male to preceed his wife in death.

The prevention of role loss as well as increase in participation in other roles to compensate for unavoidable role loss is necessary for the individual to maintain his unity of self and identity. Insofar as a lost role is not replaced, to that extent the individual has died.

The chaplain, as he has occasion, may offer support and encouragement to individuals as they work through their ever-changing roles in society which is itself ever-changing. His counsel may be of particular benefit to those grieving the loss of a spouse or adjusting to retirement. By offering spiritual hope and comfort, as well as psychological counsel, he is helping them to again become active members of society and to avert social death.

¹⁶ Havighurst, *op. cit.*



GREATER LOVE HATH NO ONE. . .

Glenn M. Vernon, Ph.D.

The euthanasia analysis presented here utilizes the Socio-Symbolic or the Symbolic Interactionist approach to the study of human behavior.¹ This approach is summarized in the ISAS paradigm. "ISAS" represents the statement that the behavior of the *Individual* is in response to *Symbols*, is relative to the *Audience(s)* and relative to the *Situation*. This incorporates multiple variables and hence a multi-causal perspective or relativity rather than a one-factor determinism. Euthanasia analyses frequently incorporate an oversimplistic interpretation which at times considers the relationship between but two variables when in actuality there are multiple variables involved in very complex ways. Human behavior is very complex.

A basic premise of this approach is that the meaning of euthanasia from which behavior stems is socially constructed and hence always subject to change. It is a human creation. Established meanings change when there seems to be sufficient conflict or dissonance to create widespread societal questions about established "truths" or answers. The U.S. society is in the midst of such a reassessment of some basic death and life facets which in the past seem to have been accepted without question. Concern with euthanasia is related to a concern with abortion, birth control, and many aspects of old age. In a sense these are all part of the same "meaning package".

Given the contemporary societal conditions, euthanasia decisions have to be made. We no longer have any choice. This article considers some of the contemporary death meanings which serve to expand understanding of euthanasia-related variables. Hopefully this will lead to decisions which will reflect the many complex societal components which are currently being related to death and life, making such decisions more harmonious with the social conditions in which those affected by such decisions actually live.

RELIGION AND EUTHANASIA

In their considerations of euthanasia, many introduce religious factors. Religion, in turn, has extensive concerns with death including euthanasia. Religion focuses upon love. Some have in effect deified the loving process and maintained that God is love. Others use an an-

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thropomorphic concept, conceptualizing God as a loving being, maintaining that the only authentic God-human relationship is a loving relationship, indicating that inasmuch as a person has loved the "least of these" he has done it unto God. It is not surprising then that religious concern has been given to considerations of how loving is involved in and related to death, with the related question of what we are in fact doing to others, even the least of these others, when we make certain death-life decisions. There are important euthanasia implications for any such conclusions, some of which will be analyzed here.

Concerns with God typically get related to high-intensity moral definitions which provide legitimation for important types of behavior. Conversely, high-intensity moral definitions, whatever their origin, typically get related to God definitions. Religious concerns incorporate both components. Our discussion here will involve both.

In our society, we have started to remove long-established taboos about death and, as one part and consequence of this change, to look seriously at many of the previously ignored aspects and implications of euthanasia. It is the purpose of this article to identify and examine some of these.

MORAL OR VALUE HIERARCHIALIZING

One of the most widely publicized and presumably widely accepted premises with reference to death and life is the moral premise that preserving biological life is the top over-riding value or the value of highest intensity. This could be restated as a belief that "greater love hath no one than he prolong his life or the life of others to the maximum." There is, it is believed, universal agreement that living is always better than dying. This belief is widely stated and accepted but accumulating research evidence with reference to actual behavior just doesn't support it.² As one illustration, it has been found that many older persons report that they fear death much less than they fear living in a dependent, incapacitated state.³ It appears, in fact, that for most of the persons facing death, preserving a positive self-image or reputation is of greater importance than preserving one's biological body. A quicker more dignified death is preferable to an undignified prolonged death. *For almost everyone, in fact, there appears to be something for which they indicate they would give their life, in order to respect and love themselves. To them the greatest love is giving or shortening their life for the benefit of others.* When a forced decision is involved most indicate that they would forfeit their life for the benefit of loved ones, especially family members. The loving, *relationship* is of greater value than the biology of the one person.

It is interesting that many anti-euthanasia defenses are legitimized by Christian teaching, or in the name of Christ. Ignored is the fact that the individual for whom Christianity is named, voluntarily gave his life for what he apparently considered to be a higher value—love of others. There is evidence that in their own realm of living and experiencing, many indicate a willingness to follow this example.

Our understanding of such evaluations is increased if we explore the nature of values, per se, to which we now turn attention.

ABSTRACT AND APPLIED EVALUATIONS

Analyses of evaluations, such as those involved in euthanasia, frequently incorporate an unstated and frequently unrecognized assumption that there is just one type of evaluation involved. Utilizing the ISAS orientation, we start with a contrary premise that there are both abstract and applied values and that our understanding of any phenomenon, including euthanasia, is expanded if this value distinction is recognized. All human evaluations, are a very distinctive type of phenomenon. Value definitions involve concepts of the type called in Symbolic Interactionism language “non-referented.” There is nothing in the empirical world to which these symbols refer. They do not stand for something else as do other symbols. They stand alone. Plato called such concepts “pure idea.” Shakespeare recognized this quality when he indicated that beauty (a type of evaluation) lies in the eyes [symbols] of the beholder. The value does not lie or is not located in the object evaluated but rather in the evaluations of those involved. The evaluation is created by the evaluators. It is not an inherent component of that which is evaluated. This point is emphasized in the Christian scriptures as follows:

I know, and am persuaded by the Lord Jesus that there is nothing unclean of itself: But to him that esteemeth anything to be unclean to him it is unclean.
Romans 14:14

Unto the pure all things are pure: But unto them that are defiled and unbelieving is nothing pure, but even their mind and conscience is defiled.
Titus 1:15

From an ISAS orientation, the evaluative behavior of the individual is in response to symbols or meaning (value definitions and other definitions) and is relative to the audience and the situation. The value definitions are a part of the “symbols” part of the paradigm. Such values are applied by people (individuals relating to other individuals) in actual experiences. These are applied values.

When evaluations are considered to be absolute, eternal, unchanging or irreformable, one apparently abstracts the value definition from the larger ISAS configuration and considers or treats it as though it

exists without any qualifiers or “relatives”. Being abstracted, it is abstract. It is not related to any actual human living variables. When viewed in this way, value definitions have no non-symbolic restrictions or qualifiers. One is concerned only with meaning systems, not with human behavior. Theologians, moralists and others may spend time analyzing value systems to attempt to make the units in the abstract meaning system as harmonious as possible—in the abstract.

Abstract value definitions, however, take on considerable complexity when attention moves to the applied level. Ideals or abstractions always lose something or acquire qualifiers when applied to specific human situations. When applying a given evaluation to a given situation, decisions have to be made as to which of the multiple variables involved are the most important variables in a specific episode. These are accordingly given greatest saliency in a configuration of complex variables. In effect, a series of abstract evaluations themselves have to be evaluated and a decision made as to which evaluation in that episode turns out to be the top priority, over-riding or neutralizing evaluation. The applied evaluation then becomes situation specific rather than universal. Change any of the paradigm components and the decision about the rank order of high-intensity value definitions may also change.

Abstract evaluations can be viewed as eternal and absolute. They are eternal if by eternal one means they do not apply to any specific actual situation. Applied evaluations, however, always have a relativistic here-and-now component. In applying evaluations, humans are not robots with behavior completely pre-programmed so that the same value definition can be applied with the same consequences in every situation. Humans rather have the capacity and *the necessity* of making decisions about their behavior and about their beliefs (meaning or symbols). Humans are “condemned” to decision-making. Making intelligent decisions about their behavior and about the meaning of such behavior is certainly one of the most influential and distinctive behaviors in which humans engage.

The complexity of human behavior in general and the necessity for decision-making is emphasized by the fact that there is frequently a conflict between what we want and what we want. We want contradictory things. Most decisions are between good and good rather than between good and bad.

We introduce confusion into our thinking about euthanasia if we fail to distinguish applied and abstract evaluations, and treat applied evaluations as though they are abstract. They are not.

SELF-PRESERVATION AND/OR SELF-DESTRUCTION

The somewhat trite statement that from the beginning of life an

individual is in the process of dying has relevant meaning for our analysis. From the start of life all human experiences have a relationship to or impact upon the dying component of living. It would, in fact, be more accurate to use the label "living-dying experiences" than just "living experiences." Life expectancy is constantly being shortened by many social or living factors. One death-hastening factor is added to another and to another until the totality of death-creating or death-hastening factors outweigh the life-preserving factors. At that time the individual dies biologically. The straw that "breaks the back" or terminates the life is but the last one added to many preceding ones. No one single straw causes the death or is the single death-causing factor.

Societal concern, however, has been focused much more extensively upon the terminal period or what we will here call the "euthanasia period" and hence upon the "last" straw than upon the gradually accumulating components (the stack of straws) and has contributed to the conclusion that everything possible should be done to extend the terminal stage as much as possible. Such justification for the terminal extension, however, is frequently presented in a universal rather than applied, time-limited perspective—everyone should always do everything possible to extend all or any life. "Life" is, of course, something that is involved from conception on, and the terminal life is viewed or interpreted as though it were the same as the preterminal living. The justification statements make no distinction between types of living or living at different periods of the life span. Hence it is concluded that there is no such thing as "life" not worth living.

Such conclusions rest upon the assumption that the decision makers know what life is and, conversely, what death is and, thus, when death occurs or when dying takes place. A label incorporating both life and death components might be more accurate and useful for some purpose. The terminal person is dying as well as living and is living as well as dying. Treatment which prolongs life also prolongs dying. A meaningful question with reference to the dying/living ratio is whether there is a point at which the death-dying component should become the major focus of concern. *Does the prolonging of life with a preponderance of dying behavior, justify prolonging the dying and delaying the death with its limited life components?* Is there a point at which major concern should be with helping a person die with dignity which would typically include dying with a minimum of pain and suffering. If the answer is "yes" then attention should also be given to the fact that there are different types of pain and suffering. Pain related to a damaged self-image can be more difficult and intense than pain related to a damaged liver.

Do the living have any obligation to help a person have a good dying experience? Should just any type of dying be equally accepted and encouraged?

MIXING LEVELS OF ANALYSIS

When one starts to study human behavior in general, there are different levels of potential analysis available. This includes (1) the level of interacting persons or the socio-symbolic level, (2) the level of the individual which considers but one person, (3) the biological level or the internal level in which biological entities inside the individual are taken into account. The internalist approach or level can involve increasingly smaller units or levels down to some sub-atomic level. The type of explanations you secure are related to the level at which your analysis is located.

Some accept as a part of their death beliefs the premise that humans have a biologically built-in mechanism such as an "instinct" of some kind for biological self-preservation. They start with awareness that the internal biological mechanisms of humans do not have to be taught to function and adapt to change. The heart, for instance, does not have to be taught to increase its rate of beating when the input of adrenalin increases. The heart responds automatically.

It is then concluded that the individual automatically follows the same behavioral patterns as the heart. The individual (of which the unlearned biological components are a part, but only a part) instinctively or automatically or in an unlearned manner, adapts to changes in a life-preserving, life-extending manner. The thinking is that if the heart automatically adapts in a life-preserving manner, the individual automatically adapts in a life-preserving manner. The major point overlooked is that there is at the individual level a type of behavior which is not found at the sub-individual or internal level. The individual thinks. The heart does not. The heart responds to biological factors. The individual responds to symbol factors. The behavior of the individual is in response to symbols which have socially constructed meaning—not meaning inherently built into them.

Analyses of euthanasia frequently conceptualize the individual as though the behavior of an individual is but a continuation of the behavior of internal biology rather than a distinct type or level phenomena. However, this is not so. A level difference is involved. The distinctiveness of individual-level behavior is evident when one observes the manner in which individuals relate to each other. In over-simplified terms, they talk to each other and think about each other. They make decisions about each other. They do not establish biological connections. Even when they come together biologically (as

in a handshake or a sexual embrace) it is the meaning of the biological union which “holds” them together, not the biology per se. Individuals can love each other. Hearts or any other sub-individual level entities cannot. Loving requires symbols.

Explanations of death, including euthanasia, which focus attention upon the biology and minimize or ignore the socio-symbolic factors of interacting individuals distort the basic human condition—individuals relating to other human individuals utilizing symbols-meaning. Such explanations ignore what might be called the “spiritual” (symbolic) nature of human interaction.

When we consider the applied nature of euthanasia evaluations and couple this with awareness of the nature of socio-symbolic systems which influence the social as well as the biological aspects of humans, it is possible to conclude that humans have an “instinct” for self-destruction or for shortening the span of life rather than an “instinct” for self-preservation or lengthening the span of life. The “instinct” involved, however, is a societal one rather than a biological one. Such a statement takes into account the life-long process of dying rather than just the “euthanasia period” of dying.

The “euthanasia period” of dying is one small aspect or portion of the total dying process. As has been suggested, dying is in fact proceeding from the moment of conception. Thousands and thousands of life-shortening experiences are introduced into the living-dying process at many points of the living-dying process. It is impossible for a person to live without having that living influence his dying process. Euthanasia decisions apply to the immediately-prior dying aspects, with the implicit assumption that these are all that should be taken into account. This point will be expanded in a subsequent section of this article.

Death-related behavior is somewhat paradoxical if we fail to take into account the nature of applied values. In actual behavior we don’t actually do what our abstract values say we ought to do. We refuse to let those who want to die die, and justify this by invoking abstract universal criteria. Yet, as a society or in the name of society we take the lives or shorten the lives of some who want to live, as in the case of capital punishment, war, and in many more not so obvious or somewhat invisible means of shortening life as when we pollute the air, manufacture defective products and engage in violent sports. We “take the lives” or at least permit or force the shortening of the lives of many who want to live longer. It is likely, in fact, that no one ever lives to the maximum possible for his biological make up—or if the biology were somehow permitted to function strictly as a biological phenomenon without any societal or “living” input.

The Roman Catholic Church ⁴ and others provide a definition of a “just” or a moral war, which turns out to be a definition of just or moral

killing. Lives cut short by a “just” war death are thereby given moral justification. Catholics are also told by their church that there are dying conditions in which those in charge are not morally obligated to make heroic or extraordinary efforts to prolong life or delay death. To institute extraordinary efforts in some cases would then be defined as immoral.

Such a moral stance illustrates the previously made point that abstract “thou shalt not kill” statements, when applied to specific interaction, become applied and in the process acquire qualifiers. The parents of Karen Quinlin for instance, were told—according to popular press reports—by their church that to terminate the treatment would be moral.

The concept of “just wars” involves an ISAS perspective. Some types of dying are moral. Others are not. Those who insist upon utilizing only an abstract or “eternal” evaluation system then are faced with somehow justifying deaths which are defined as moral but which violate the eternal-abstract standards. This may be difficult.

PLAYING GOD

“Playing God” is one of the phrases to which anyone who seriously investigates the euthanasia conflict is exposed over and over again. Just what “playing God” means, however, is usually not specified with clarity. It is for many an action-oriented concept designed to influence anti-euthanasia behavior rather than an analytic concept. The implicit unstated assumptions of the “playing God” concept need to be explored. Our comprehension of the complexity of the euthanasia conflict will be expanded if we look more closely at some of these unstated assumptions.

It appears that “playing God” means interfering with the human biological process, especially not letting biological processes run their course in their own unimpeded way. A person then should die when his biology stops or when his biology is ready to die. Dying is a biological process. With reference to euthanasia “playing God” means not letting the death be a biological phenomenon or not letting biological factors “cause” the death.

If “playing God” means influencing human biology, then behaving in such and such a way is discouraged if such interference shortens or influences the very last stages of living. However, “playing God” or influencing biology is encouraged if this means *lengthening* the time of living especially during the pre-euthanasia period. Such lengthening involves such acts as having an operation, inoculation, diet, and disease treatment.

Another paradox is involved. Those who are engaged in doing all they can to supplement biological processes and thus delay the death which would happen very quickly if they stopped “interfering” with the biological processes, are frequently the very ones who charge that “interfering with biology” is playing God and hence is an activity better left to God than usurped by humans. Those “playing God” to delay death, ridicule and condemn those who would “play God” to facilitate death.

It is somewhat surprising that those frequently engaged in extensive efforts to delay the death through use of human skills, knowledge and machines conclude that to decide to use such mechanisms is not “playing God”. It is just being human. However, to decide to turn off the machines or not to use them in the first place, is “playing God”. One set of human decisions is seen as involving humans doing what ought to be left to God to do while the other decisions are seen as doing what ought to be left to humans to do. Each type of decision influences the biology of humans and either course requires human decisions.

If rather than defining one type of decision as a God-like decision and the other as a human-like decision we consider both to be human decisions, we reach different decisions about the death and life aspects of such behavior.

Those who make these “playing God” charges never seem to specify just what it is about the one human decision which justifies “deifying it” or dehumanizing it, and what it is about the other contrary human decision which justifies “humanizing” it. How can one human decision be God’s good decision and the other human decision be the “devil’s evil” decision? Either influences the biological process of the dying person.

“Playing God” objections tend to ignore the social-symbolic aspects of most deaths, incorporated in the total living experience of individuals. A biological factor or system in fact literally cannot “do its own thing” or function alone or independent of socio-symbolic factors. No biological system exists in isolation.

“Playing God” interpretations tend to avoid the human responsibility for the timing of death, thru what we might call “supernatural scapegoating.”

Further we tend to interpret the “will of God” as functioning within a clock-time rather than an event-time system, or within what we might call a celestial time system designed for eternal living. God decides according to some clock-time or mechanical time system, the hour and the minute a person should die. In an event-time system, the person dies when his life-event, or his living is completed. In effect, the person, the biological-intelligent person dies when he is ready to die, not according to some pre-programed schedule.⁵

The "God" component of the "playing God" concept suggests that the euthanasia objection involved is an objection to humans doing something which interferes with God's will. This then relates to the point to which we now turn attention about how humans reach decisions about the will of God.

DETERMINING THE "WILL OF GOD"

Some maintain, implicitly if not explicitly, that the will of God is made known thru the biology of humans or more precisely thru the biological changes. Biological change is caused by God. God "speaks" to humans by doing something to the human body. When the biology changes it is God who is responsible for those changes. This type of thinking is frequently included in evaluations of both birth and death, especially in arguments about birth control and death control.

This thinking seems to ignore the fact that the biological individual always lives in a socio-symbolic environment and in an empirical-natural environment. It endorses by default the premise that NO influence (when a person dies biologically) is exerted by the individual's social experiences, as well as the individual's symbolic-meaning experiences (his decisions) or the meaning he realizes AND the nonhuman environment in which he lives and from which he derives his physical-biological sustenance. It also fails to take into account the fact that death rates vary from society to society and from one sub-societal group to another.

It is possible to amend the "God speaks thru changing biology" to include the premise that the social-symbolic and the nonhuman physical environment influences the biological changes but that these change-influencing factors are controlled by God or possibly predestined by God. God's will then is involved in or made known thru the physical environment, which influences the biological changes, which then are a manifestation of the will of God. All of the factors which contribute to an actual death are then conceptualized as being God controlled. All human living experiences then are controlled by God. Such an interpretation is diametrically opposed to an ISAS perspective. Such interpretations take the "human" component out of human experiences.

The selectivity of the perception in such interpretations is somewhat amazing when one examines it closely. Individuals spend a lifetime relating to others, being influenced while influencing others, learning meaning or acquiring knowledge from others and dispensing knowledge to others. Individuals spend their lifetime securing food from the physical environment and, at least since the time of Malthus,⁶ developing a concern with the relationship between food supply and

the human living condition, maybe accepting some version of the Eden story that humans in fact live by the sweat of their brow (and die if they do not work hard enough) and then in interpretations of dying they imply that such factors really have no influence upon dying behavior. God speaks of influences thru the biology, but not the society or the environment. Such thinking, by ignoring the influence of socio-symbolic factors, by default deifies the society-environmental factors which influence the death related biological changes. Such thinking tends to deify the status quo. If God is responsible, why should humans attempt to change the society? On the other hand if humans are seen as being responsible, then an effort on the part of humans to introduce change is appropriate.

Such thinking is facilitated by defining dying as that which happens just prior to death. Such thinking becomes untenable if dying is interpreted as that which goes on all the time.

The human ability to make decisions, especially value-moral decisions is a most distinctive and some would say the most Godlike human ability. The Eden story suggests that it was in learning *how* to consume or use knowledge of good and evil that humans became as the gods. Such an orientation discredits beliefs that God's will is known thru biological change, suggesting instead that the will of God is known thru the mind of man or thru the decisions which humans make. God's will is known thru the intellectual decisions of humans not thru biology. Actually even the decision that God's will is known biologically is itself a symbolic nonbiological phenomenon. Mormons have an expression that the "Glory of God is intelligence" which can be interpreted as also meaning that the glory (or the most Godlike quality) of humans is intelligence. This then raises the interesting question of why God would influence the biological changes of humans to express his will but not the more Godlike intellectual processes. If God's will is made known thru the intellect of humans, the sincere decision to influence a death then is granted religious-moral legitimation and it is possible to conclude that for specific individuals in specific situations that greater love hath no one that he shorten his life.

From an ISAS perspective then, *the most meaningful question about euthanasia is not whether one is for or against euthanasia in some absolute, abstract manner. It is more meaningful to inquiry whether particular types of dying are appropriate for certain types of persons with certain biological conditions, when such dying has certain types of meaning to the person dying as well as to the others to whom his behavior is related in particular situations. Dying behavior is in response to meaning, relative to the audience involved (including the self audience) and to the situation.*

FOOTNOTES

1. For a more detailed discussion of this approach and the ISAS paradigm see Glenn M. Vernon, *Human Interaction*, 2nd ed., New York: Ronald Press, 1972.
2. See Glenn M. Vernon and William D. Payne. "Myth-Conceptions about Death," *Journal of Religion and Health*, Vol. 2, January 1973 pp. 63-76.
3. See Glen M. Vernon, *Sociology of Death*, New York: Ronald Press, 1970, Chpt. 7.
4. See Glenn M. Vernon, *Sociology of Religion*, New York: McGraw-Hill Book Co. 1962, pp. 141-2.
5. See Glenn M. Vernon, "Dying as a Social-Symbolic Process," *Humanitas*, Vol. X February 1974, pp. 21-32.

A PRIMER ON HUMAN GRIEF

Chaplain (LTC) Donald H. Welsh, USAR

Numerous books and articles have been written on death and dying, and grief and bereavement during the last decade. Public interest in these natural phenomena is evidenced in our communities and on our college campuses where an ever-increasing number of courses, seminars and workshops on death and dying are now being offered. Unfortunately, this proliferation of academic endeavors does not guarantee that all members of the helping professions (the clergy, physicians, social workers, nurses and psychologists) will gain a “working knowledge” of death and its related processes. In fact, many health care professionals have at best a rather vague awareness of what grief entails and have little understanding of its tragic and often catastrophic consequences.

The purpose of this paper is to present in cursory fashion a primer on human grief. It is my hope that chaplains will find it useful as a skeleton upon which to build their own fuller understanding and appreciation for grief, recognizing its frequent intrusion into their personal lives and the lives of those persons to whom they offer spiritual ministry.

My own understanding of grief has developed through a pilgrimage of more than a dozen years. It began in the mid-60s when I attempted to minister to approximately thirty widows whose husbands were killed in Vietnam. These women and their children seemed to need a specialized type of support which they said they were not receiving. I was saddened when my best efforts as a clergyman were often ineffective in ameliorating their pain. A subsequent assignment to a combat battalion in Vietnam exposed me to sudden hostile death and left its mark upon my spiritual and emotional health when I returned home. I was significantly relieved to recognize that my agony was, at least in part, a natural grief reaction. The next milestone along this pilgrimage was my release from active duty to accept an appointment as a chaplain in a Veteran Administration Hospital. These last six years have offered extended opportunities for involvement with dying persons and their families. A crucial event took place three years ago, when a friend and colleague, a psychiatric clinical social worker, suggested that we establish a class for hospitalized patients to consider the dynamics of grief using didactic methods. It was her idea that I teach

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the class and she was to function as a collaborator. We founded an open-ended class which meets weekly with patients, nursing students, psychology interns, volunteers, and hospital staff members participating as students. Since its inception, more than two hundred patients and an untotaled number of other persons have attended the sessions. The formulated concepts that are expressed in this primer have grown out of my pilgrimage among suffering persons who have taught me so much about what it means to really live and lose and return to living again. Of course, I owe a debt to Erich Lindemann and others who have followed his lead in struggling to understand grief and to communicate this in their writings.

DEFINITIONS

The following definitions are an essential starting point in understanding human grief.

GRIEF is all the emotions surrounding and related to significant loss.

ANTICIPATORY GRIEF is all the emotions related to the expectation of a significant loss.

PREPARATORY GRIEF is grief experienced by one who is preparing to lose something of significance (i.e., the dying person "prepares" to die while other family members "anticipate" the death).

MOURNING is prolonged grief initiated by the event of the significant loss.

SIGNIFICANT LOSS is to be deprived of someone or something that is essential to meaning and satisfaction in life.

BEREAVEMENT is the period of time during which the deprivation is subjectively experienced.

THE LOSSES

Grief is always related to loss. Among the more prominent and consequently more painful losses encountered by persons, are:

1. Death of a spouse
2. Divorce
3. Death of a child
4. Loss of a body member (limb, eyesight, breast, hearing, hysterectomy, speech)
5. Death of a parent
6. Retirement
7. Separation (including relocation)
8. Marriage

9. Loss of a job
10. Loss of health
11. Loss of dreams

These are experienced as grief! We often see persons who are suffering from multiple losses simultaneously. A key loss may trigger subsequent losses. For instance, a person going through a divorce may lose his health, his home, his children and even his job; or, a person relocating may lose contact with family and friends, familiar environment and routines, and effective support groups (church and school, for example).

In a society that recoils from suffering and seeks comfort, it is not unusual to meet a person who is still enslaved by grief years after the loss. This prolonged agony is probably due to an attempt to avoid the pain of actively grieving. When a new loss occurs before a prior loss has been resolved, the person is forced into an even more complicated and stressful situation.

When we increase our awareness of the losses people sustain, then we are able to recognize and deal with the related emotions.

THE EMOTIONS

The emotions related to loss run the gamut from despair to heartfelt relief that a loved one suffers no more. Among the most common feelings are fear, sorrow, anger, guilt and relief. Feelings of hostility, rage, sadness, depression, helplessness, loneliness, anxiety and envy are characteristic responses to this kind of deprivation.

Our infatuation with psychological jargon has led us to label reactions to grief as being "normal" or "abnormal" depending upon the degree of social impairment. While outward behavior may be described as normal or abnormal, the risk is that we may come to think of grief itself (the emotions surrounding loss) as being "normal" or "abnormal." Grief is neither. Grief is *natural* and we would be wise to expect it when loss is imminent or recently sustained. The axiom is: *When we lose, we grieve.*

We can be immensely helpful when we recognize the loss and actively encourage the grieving process. To do this, we have to be sensitive to the emotions and deliberately encourage their expression. For me, there is no nobler form of ministry than to serve as a catalyst for the griever to ventilate his feelings.

Since dying has become a prolonged process for a large segment of our population, it is essential that we remind ourselves that grief usually precedes the death event. Carl A. Nighswonger knew the importance and benefit of synchronized anticipatory grief. In his article, "Vectors and Vital Signs in Grief Synchronization," he encourages

the helping professionals to facilitate open and honest communication between all parties. Conspiracies of silence and avoidance of discussion of feelings related to a poor prognosis inevitably result in isolation for the dying person or a rupture in close relationships. Synchronization of anticipatory grief and open communication is easier when these emotions are understood to be natural.

This task is even more critical for the dying person who stands to lose more than anyone else. Unless we are able to accept and allow (and then encourage) him to fully express his needs and feelings, we may foster his sense of isolation. When this happens, "final things" that need to be done may never be accomplished.

So far we have talked about the natural emotions surrounding death. The same dynamics may be present for the person preparing for retirement. This is particularly so when a person is forced to retire at an arbitrary age or when he or she has completed a specified period of employment, without regard for state of health or the quality of work. One's grief may be blocked by his belief that he should be grateful for the prospect of more freedom and leisure time.

I was recently reminded of the significance of divorce as a grief experience by a young widow who said to me, "I am actually fortunate . . . My husband died in a car wreck and many people have gone out of their way to help me in my time of mourning. My neighbor is the same age as I and was recently divorced. She is having an awful time . . . no one helps her!" There it is. When we fail to consider divorce as a grief experience very closely paralleling death, we have cheated ourselves and others.

STAGES

The stages of grief are presented differently by various authors. Granger Westberg outlines ten stages: (1) Shock and Denial (2) Emotional Release (3) Utter Depression, Loneliness and Isolation (4) Physical Symptoms of Distress (5) Panic (6) Guilty about everything related to the loss (7) Hostility (8) Lassitude (9) Realization of how unrealistic we have been (10) Readjustment to Reality. His paper written for the American Medical Society is concise and clear. I find it useful for the mourner.

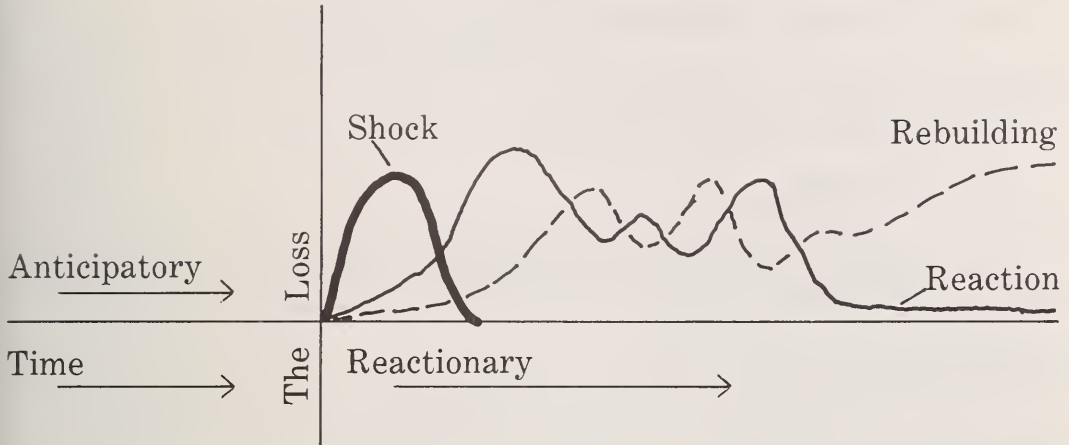
Kreis and Pattie in a beautifully written little book, *Up From Grief*, describe three stages of grief: (1) Shock (2) Suffering, and (3) Recovery. This is an exceptionally poignant account of one widow's struggle to re-emerge from the throes of mourning.

I schematically present the grief process as three stages:

1. Shock and denial
2. Reaction
3. Rebuilding

STAGES OF GRIEF

1. Shock and Denial
2. Reaction
3. Rebuilding



It is important to note that as graphed here, all three stages begin simultaneously at the event of loss. The first stage, Shock and Denial, reaches a definitive end. Reaction and Rebuilding continue for longer periods depending upon the meaning of the loss for the griever.

Anticipatory grief has essentially the same stages of reactionary grief. Living through anticipatory grief does not automatically guarantee a commensurate lessening of suffering in the reactionary process.

THE GRIEF WORK AND OUTCOME

A frequent declaration of the widowed person is, "I just know I'll never get over this." Tragically, some never do. Others suffer the same intense pain and happily do recover. They complete the travel and growth from near destruction to resurrection as a new and stronger person. Completed grief work leaves its scars, but compensates with deeper insights, faith and courage.

We tell our students, "Grief can be cured!", and we stress the importance of doing grief work. The following formula was developed to illustrate our working hypothesis:

$$3A + E + 2C + D + T \rightarrow R$$

3A {
 Aware of the loss
 Aware of your feelings
 Accept your feelings

E Express your thoughts and feelings

2C { Consider alternatives
Chose an action

D Do something (even the routine)

T It all takes *TIME* (You can't rush it, but you can block it!)

→ Yields

R Recovers

This reduction of process to symbols is presently being used by several counselors doing grief therapy as a guide to assist mourners to "walk through" their grief.

Frequently a person will resist doing grief work because he equates recovery with being disloyal to the one who has died. Recovery is not achieved by forgetting the past, nor by abandoning the deceased. Recovery is accomplished when the fetters that would hold one slave to the deceased are unlocked and he is able once more to move about as a self-directed person. The purpose of grief work is emancipation and self-actualization for the bereaved.

THE LANGUAGE OF GRIEF

The primer would not be complete without reference to the language of grief. It is always personal. James Hodge says, "It always involves a feeling of personal loss . . . For example, if my wife should die, I would feel it personally. I would be sad and I would grieve. Now notice how I said this: I WOULD GRIEVE . . . I . . . I . . . I . . ." ¹ The pronouns of grief are "I, Me, My, Mine"—first person singular.

I suggest that we as helping persons dissuade any attempt by the mourner to feel guilty for constantly referring to himself.

CONCLUSION

It is hoped that the guidelines set out in this primer will lead to more effective ministry to the bereaved.

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A DEATH IN THE FAMILY

Ch (MAJ) David C. Coulter, ARNG

Our son, Ken, died suddenly one night. We were totally unprepared for his death. The experience for us was shattering, and our "recovery" has been slow. It has been nearly eight years since Ken died. Although we are functioning pretty well now, the emotional scars are present. We still find ourselves lying awake some nights. My wife, Lois, gets more anxious than she used to when one of the other children is sick. When we check on them when they're asleep, we make sure they're alive. We'll never "get over" it.

Ken was born July 29, 1962; he died March 7, 1968, nearly six years old. He had been placed in our home for adoption for his fourth birthday, and we adopted him within a year. We were his fifth set of parents—really his sixth because his mother gave him up to foster parents and then took him back in the first year. Our life with him was a mixture of joy and frustration. He was a delightful boy, and he captured peoples' hearts with his soft warmth and his need for love. He came to us with serious emotional problems. His life had been a struggle from the beginning. He seemed alone much of the time, fighting, often succumbing to forces which seemed too strong, trying to make it as best he knew how. We all believed we were beginning to see "the light at the end of the tunnel", and then he died. Just like that.

The events leading up to his death are vividly remembered: His kindergarten teacher calling to tell us he was acting strangely. The doctor saying over the phone "Don't worry since he doesn't have a fever." Telling him at supper to stop making the strange grunt in his breathing. Holding him in my lap because "it hurt"—he couldn't say where exactly. Sleeping fitfully. Praying, "God, help me to be a good father to Ken." Lois checked him often. At 6:30 a.m. she tucked the covers around him. At 7:30 he wasn't breathing. I rushed him to the hospital. The doctor examined him. He was dead. The autopsy report said, "bilateral fulminating pneumonia".

Now, eight years later, I am able to put our experience into perspective. The specific events of Ken's death are unique to us, but I believe the dynamics are more general, probably shared by all parents who experience the death of a child. There are special burdens felt by these parents. There are also special problems for the chaplain/pastor of such a family.

I am convinced that an important factor in our grief as parents has been the special sense of responsibility we felt for Ken's life. This

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sense of responsibility for the child is unique to parents; no one else feels it. It begins the moment a child becomes a part of the life of the parent. Ken was dependent on us for everything basic in his life. This dependence became engrained in our own being, even though we had been his parents for a relatively short time. We parents adapt our lives to the needs of our children. Although a child may outgrow earlier needs and total dependency, and the parents may no longer feel the *requirement* to be responsible for his or her life, they are emotionally *prepared* to be responsible for that life at any time.

Because the child's need for the parent becomes part of the parent's own being, it exists independent of the child's life. In addition to the great loss we felt in Ken's death, we also felt a longer lasting internal frustration and conflict which derived from our internalizing his needs, our feeling responsible for him, and his not being here.

Related to this frustrated responsibility is a sense of frustrated hopes. All parents are moving toward goals as they raise a child. There is the general objective of helping the child develop into a fully functioning adult. There are a host of more immediate goals. We looked forward to the day Ken would be able to relax, to be able to flow with life—trusting it, feeling that he was okay. He had just been showing signs of making definite progress. He and the rest of the family were very happy and proud. Then he died. It doesn't seem right or fair to have all the hopes, the expectations, the joy and excitement just vanish like a vapor. We feel deep disappointment. There is so much Ken might have become, if he had had the time!

The hopefulness, the sense of expectation, also becomes part of the parent's being. The whole course of parenthood is guided by it. When the child dies, the hopes die, but the hopefulness is still there. Again, the bereaved parent is torn apart; hopeful without hope.

The frustrated senses of responsibility and of hope manifest themselves in a feeling of failure on the part of the parent. *Strongest is the feeling that somehow I should have been able to keep the child alive. At least I could have done something I didn't do.*

It is always possible for a parent to look back and say, "If only I had. . ." In our case, Lois says she thought about taking Ken directly to the hospital emergency room. Now she wishes she had, because then the pneumonia might have been detected and treated. Although she is well aware that Ken almost certainly would have died anyway, she feels she didn't do all she could have done to save him. Such thoughts torment a parent for a long time afterwards.

The guilt we feel is real and strong. In some ways it is unreasonable; after all, there are some things we were not able to do. But to recognize that does not affect it. It stays with us, and we learn to live with it.

To try to dismiss it or to find excuses, even legitimate ones, just won't work. We know we might have done things we didn't do. Because what we did failed tragically, we wish we had done something else—almost anything else.

This guilt is compounded by our remorse for some of the frustration and anger we felt while Ken was alive and the treatment we gave him. He gave us a hard time, at times taxing our skills to the limit. At times we were rough on him. We believe that we are better than average parents, that our home is filled with love. Ken made us painfully aware that we are not perfect parents. Our memory of him has unpleasant experiences which stand out because the pleasant experiences are dimmed by the tragic nature of his life and death. Although other parents may not have the kind of difficult times we experienced, they will remember unpleasant experiences with their child, and their guilt over these will add to their guilt from the child's death.

The years since Ken's death have been a mixed bag. As I look back, I see us making a long, slow climb out of an extended depression. There have been some external factors which have added to the slowness of the climb, and I'm not sure how much to attribute to Ken's death, probably much of it. For me, there has been a lot of difficulty finding satisfaction in my work. Not that it's been bad; it's just had a lot of "blah" that I couldn't get a handle on. As time passes, my life does get more vibrant. Lois evidenced a lot of tension and anxiety for a long time, but these have faded. She is finding life more enjoyable all the time. It has taken us a long time.

All of the above about frustrated responsibility and hope, guilt and depression suggest some guidelines for the chaplain who would minister to bereaved parents. Let me comment first on the ministerial "styles" we encountered; they seem to typify pastors in general, I think.

Within an hour after I returned home from taking Ken's body to the hospital, the first minister called. He was neither our pastor nor a particularly close friend, though we had known him for several years. He was told about Ken's death by a member of his church who was the nurse in the emergency room of the hospital. Like so many pastors, he wasted no time in getting over to see us. Really there is nothing to criticize in that. But we weren't ready for him. I guess his visit was a nice gesture, but it was little more than that to us. I rather resented what seemed to be an efficient discharge of his duty.

The warning to chaplains that comes out of this experience is to be careful about those times when a pastoral visit is seen functionally—when it is a duty to be performed. Believe me, the people can see through it without even trying. The chaplain also ought to be careful

not to become preoccupied with what he does—the functions he performs or the services he provides. He ought to be free from those types of concerns in order to concentrate on the feelings and needs of the people.

The second style we encountered typified ministers who have a hard time letting their feelings flow. At the time of Ken's death, I was a campus minister and a staff member of a Methodist group ministry (a cooperative program of the churches of several communities in the area). The two senior ministers in the group, both from a nearby city, came together to visit us (primarily out of a sense of obligation to their colleague, I suspect). They seemed ill at ease and distant. This became apparent when the conversation shifted gradually until they were talking between themselves about the church school program in one of their churches! Lois and I sat as awkward bystanders. In a short while they left and we were relieved. We sensed no comfort from them, probably not because they didn't want to give it. There was something which made it difficult for them and us to open the way for comfort to flow.

I am not sure what hindered the flow of feelings with these two men, for we were friends and they both are known as good pastors. I think part of their awkwardness may be attributed to the fact that they didn't know Ken. In this respect, their situation may not have been unlike that of many chaplains. I think it is important for the chaplain in such a situation to acknowledge to himself that he didn't know the child. He needs to be aware of how little the child's death affects his own life so that he will be able to recognize how much it affects the parents'. There is a gap in the grieving between him and the parents, and there is really nothing he can do to overcome it. To recognize this will make him less self-conscious and ill at ease.

The minister of our church (as a campus minister I had no parish and we participated as members of a local congregation) had a "style" of ministry which really was no style at all. I would have discounted it, if I hadn't experienced it, but we appreciated it greatly. We found comfort and support from him, and our respect and affection for him continued to grow after the funeral was over.

He simply was there—literally. During his first visit he just sat with us. He didn't say a word for twenty minutes, but by a gentle, affectionate presence he seemed to say, "I know your suffering is beyond where my words can reach. I won't violate that or try to gloss over it. I'll simply try to absorb some of it for myself and to enter into it with you." (He had baptized Ken, and our families were close friends, so he had some grieving of his own to do.) It really was very comforting just to have him there.

The funeral service he conducted simply affirmed that Ken was important to us and to God. Although I had listened intently to every word at the service, when I returned home I couldn't remember what had been said. Fortunately, he had written the entire service and was able to give us a copy; we treasure it.

Immediately following the funeral there was a great letdown. Where there had been activity, planning, people, talking, now there was quiet. It was both pleasant and difficult. Before the funeral the continual greeting of visitors and reciting the story had been almost too much to bear. Now there was an instant vacuum—nothing to look forward to, and a strange silence. We began to feel our loneliness, particularly Lois, who was at home every day. For several weeks the pastor was a welcome friend as he made regular visits.

I do not think it is helpful for the chaplain to try to comfort parents by giving little sermonettes designed to give the answers of faith to the parents' problems. Traditional statements about God's will, forgiveness and hope, seem hollow to us. The experience of grief is too profound for words, particularly those given as prescriptions. Words in general, as I noted about the funeral, were absorbed by our numbness in the state of shock after Ken's death. I suspect this phenomenon is universal.

At the risk of seeming redundant, let me affirm from the perspective of experience, that the chaplain ought to be sensitive to the depths of feelings of bereaved parents—especially to their sense of responsibility for the child's life, their sense of failure, guilt and lost hopes. When the parent expresses sorrow, it is more than sadness. However it is expressed, it is to say, "I'm sorry," in all the meanings of that term—confession, anger, pain, regret. When the parent says, "I miss ____," he/she speaks not only of feeling the absence of the child but also of feeling the force inside created by the vacuum. The fortunate chaplain will be one who somehow reaches out with his deeper self and touches those feelings. He may not realize it at the time, but he will have comforted and supported.

A chaplain can really help bereaved parents by being able to live in the presence of death, by accepting it without having to shield himself. He will do much for them by just being there—not making excuses, judgments, pronouncements, not running away from them, their feelings, or his own, recognizing his own inadequacy, and trusting the relationship itself to give help and strength.



REFLECTIONS AT THE BORDER

Chaplain (MAJ) Richard A. Johnson

I am more than a little hesitant about publishing these notes.

I firmly deny all accusations that I am either a scholar or a theologian, a denial which will become self-evident in the substance of these reflections.

My only qualification is that I am dying, and that is really not unique. You are dying, too. The only difference is that I may know the name and, to a degree, the time of my dying while you may not.

A recent trip to a bookstore convinced me that dying has become stylish. Everybody is doing it, or at least everybody seems to be writing about it. (My impulse to leap off crowded bandwagons adds to my hesitation about this project.)

This is not a "how-to-do-it" article, either in terms of how to die or how to minister to the dying. For instruction in both of these tasks I would point you to the Scriptures. My aim is much more modest: I would share some of the lessons I have learned about myself, about others, and about God. I would say some words about discovering abundant life in the shadow of death.

"Celebration" has been used so much in recent literature that I am not sure what it means. (I have that problem with many contemporary theological terms.) If it means what I think: the total, significant, and joyful experience of an event, then I want to celebrate each day of my life. I want my writing to be a partial account of that celebration.

These notes are very personal and they have both the advantages and disadvantages of such reflections. Only a few were written with a view to publication and all grew out of a life-long habit of writing to myself. They come from a four-month period, from the time I learned of the nature of my illness to the present moment.

* * * * *

Patients expire, victims are DOA, loved ones pass away, leaving remains to be viewed; but people, you and I, die. Death is our current obscenity. Although some of us mouth it as the current four letter word, most surround it with euphemisms and cosmetics. I find it interesting to see how different people deal with this new obscenity. I am gross; I brook no euphemisms. For some, I fear I am like the ghost at the banquet (somewhat prematurely, I trust).

In refusing to recognize our own mortality, we cut ourselves off from an important and rich part of life. We expend energy in denial

more

which might be used in living. May I shock you into savoring life at the edge of death? The rare flowers grow at the edge of the cliff and we both may find joy there! Perhaps the shock is not necessary; if so, so much the better.

* * * * *

Some friends, chaplains and others, encouraged me to think of myself as unique. Other wiser friends helped me to see that this is a subtle form of distancing. Those who would make me unique were doing two things: they were allowing me to set myself apart; but in addition they were denying the reality that they were one with me in their own mortality.

Without simply saying that misery loves company, I beg to remind you that I am *not* unique. Not in the category of life and death, at any rate. By separating me into a unique category, you are saying, "It won't, it can't happen to me. Dying is special, but not for me."

Remember, when you "minister to the dying," you minister to an abstraction, but if you will be my friend, we will be living—and dying—men together. It will be costly, but it may be wonderful.

* * * * *

When they told me I was "dying," I first felt a certain freedom. It was a freedom from the ambiguities and pressures of daily life.

Now time has passed and I discover that I still am in bondage to life. I will continue in this condition as long as breath lasts. Yet my bondage has changed. Life cannot compell me as it did before. In a very small sense I have been given an illustration of St. Paul's concept of life brought back from death.

In Romans 6, Paul talks of our incorporation with Christ in death and our rising with him in new life, life that is never the same. In a sense my experience is a paradigm of this concept. The fact of death gives me freedom that is actualized in Christ so that I may return to life. In faith I must look at life as if I have been raised to new life. The old bondage is gone, at least to the extent that I am willing to let it go. I am free, not in death, but in Christ.

It is sad that it takes an experience of this nature to make real what should be normal for every Christian.

* * * * *

In T.H. White's beautiful fable of the young King Arthur, *The Sword In Stone*, the young king-to-be, about to draw the sword from the churchyard stone, finds himself surrounded by magical friends

from a brief life of love and wonder. They are all there to encourage him and to cheer his victory. Because he has given himself to them, they are there to give of themselves to him.

I feel much like young Wart, unsure of what is before, yet surrounded by love and prayer.

* * * * *

Where does life begin? Where does the wind begin? Where does life end? Where does the wind end? Can you halt life by holding it? Certainly; as readily as you can halt the wind! Many try; they beat against it and are exhausted by their efforts. Others go straight on, covering their eyes against their destination. Still others cling to the earth, but it moves also, suddenly and violently. A few are like skilled sailors, sometimes running with the wind, sometimes tacking, but always cooperating with the laws of the wind as they move toward their destination. Whether long or short, their voyages are marked with grace.

* * * * *

A “Me—They” relationship has developed between me and most of the physicians who are treating me. They are obviously interested in my well-being, although it seems that the interest arises from the fact that I am an interesting “case.” But, in any case, the relationship is to be on *their* terms. They are to be the physicians, nurturing, but distant—oh, so very distant Parent—and I am to be the patient, a compliant Child.

I struggle to remain a person in this very important relationship, an adult in charge of my own life and ultimately in charge of my own death. (Is this arrogance? I think not, because I am speaking of human relationships and am looking beyond them to my standing as a son of God.)

So far I have met only two physicians, fortunately they are the ones who are caring for me now, who appear to be willing to meet me on my own terms. They are willing to look at my disease and eventual death as a joint problem upon which we must “co-operate”. Their honesty is a high affirmation. We meet only in one context, but there are no games in that meeting.

* * * * *

They tell me that I have my “stuff” together. I’m not sure I know what that means.

It can’t mean that I’m not afraid. Fear is real and I live with it day by

day: chiefly the fear of the unknown, and the fear of the indignities of dying. (A pastor, I know dying is seldom dignified.) Added to these fears is a list of the normal worries of living and the anxieties of retirement. What is more, I am willing to talk about my fear—at length.

It can't be that I am not angry and depressed. There are times when I decide that I have invented depression. Aside from my present situation, I've a lifetime of persistent pessimism to fall back on.

It is not that I am not dependent, querulous, and a host of other negativities. If I've got my stuff together, these are all here, too. Perhaps this is it. I allow myself to acknowledge each of these parts of me and, haltingly, allow God's grace to work on them as well as on the good stuff.

If I can allow the fear, the anger, or the depression to emerge, then they are no longer a big deal. Available to the operation of grace, they cease to be controlling factors. In and around them I can discover God's love and joy. I can also discover people, who, like me, must find the richness of life in the midst of spiritual poverty.

These things, then, are all part of the real me—the me that God loves, the me that Christ died to redeem. Only as I am able to acknowledge this me, am I able to realize my redemption.

* * * * *

Am I grandstanding? I don't know. A friend tells of an award for valor: "There was nothing brave about what I did. I *had* to stay there; there was no place to run."

This is rather where I am. I can't run from my own circumstances. I have only two choices: to live in fear and misery, dying a little each day; or I can live abundantly in the promise that Christ has given me. In so far as it is possible, I choose the latter.

But at the same time I will not deny, I will not euphemize my own situation. I am dying and I will be blunt about it to the point of shock. This may be grandstanding as well as "bad manners", but at least it forces me and the people for whom I care to deal with my dying in terms of reality. With the shock there is no room for sympathy. I also believe that I have something to say that is worth hearing.

* * * * *

What do I want from you? First let me tell you what I don't want.

I don't want platitudes and reassurances that we both know to be false. Falsehoods only serve to create distance that I neither want nor need.

I don't need sympathy. It will also serve to reinforce my weakness

and I am weak enough as it is.

I don't want head-tripping and three-dollar words. I've used enough of them to know how meaningless they can be.

In other words, I don't want to be an object. I wish to be recognized for what I am: a person engaged in the business of life.

What do I want?

First of all, I want honesty, even though at a given moment I may not care for the results. I haven't time for games. If I turn you off, or trigger your fears, or fail to meet your preconceptions of a "dying man," let's deal with it. If you think I'm being too morbid; tell me about it.

I need hard contact. Depending on who you are, the contact may be needed on one of several levels: intellectual, spiritual, physical, emotional.

There are times when I need help. There are things that I can no longer do for myself without a great expenditure of energy. I need a friend to help me do them. There are other things I'd rather do myself, even if the results are awkward. It is also an effort to ask. So ask, if you will, but let me say, "No, thank you."

I need people with whom I can share my discoveries. In itself, dying is meaningless. It is up to us to give it meaning, or, more accurately, to discover its meaning.

I need people with whom I can be honest about my feelings. There are fears; there are angers; there are sadnesses. There are times when courage runs very thin and faith becomes a theological abstraction. In dealing with this, we can minister with one another.

I also need people with whom I can play. I don't want to turn into a character in a Russian novel. It is dangerous to take either life or death too seriously. If we can see that life *is* a divine comedy preparing us for heaven or for hell, then death becomes simply another incident. There are times when it is important to say, "Situation hopeless, but not serious." The Master said, "Be of good cheer, I have overcome the world." So let's find time to play.

More than anything else, I need to tell you about the joy I've found in Christ. Years ago I was called to be a preacher, a teacher, and a counselor. My illness has not cancelled this call. I intend to practice my craft as long as I am physically able. But this telling goes beyond any call or craft. I have discovered in a new way that the promises are real. Once more I have discovered that because out of God's love, Christ died for me and I have the assurance of eternal and abundant life, even at this present moment. The seal is God's Holy Spirit who gives me the daily wherewithal to function, not as a super-Christian, but as a redeemed sinner, living one day at a time until that day I discover the final dimension of life and find myself complete in him.

* * * * *

It is harder to stop than to begin. The chief difficulty with most stories is finding a satisfactory ending. They will go on and on. So it is with life. I will go on. I have just begun to learn a little bit about love and grace and trust. But we are told, and so we believe, the best lessons are yet to come. Peace.

no more

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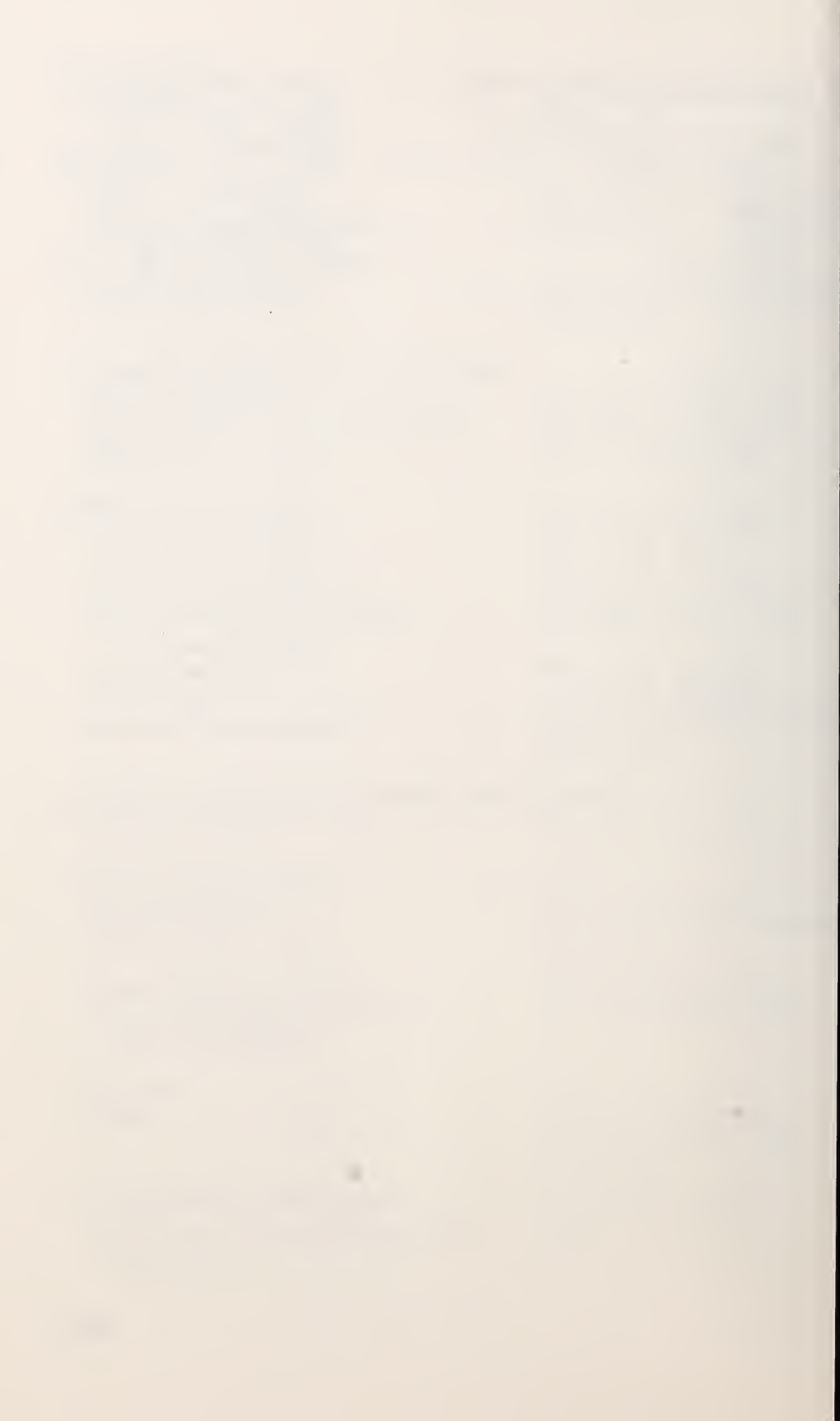
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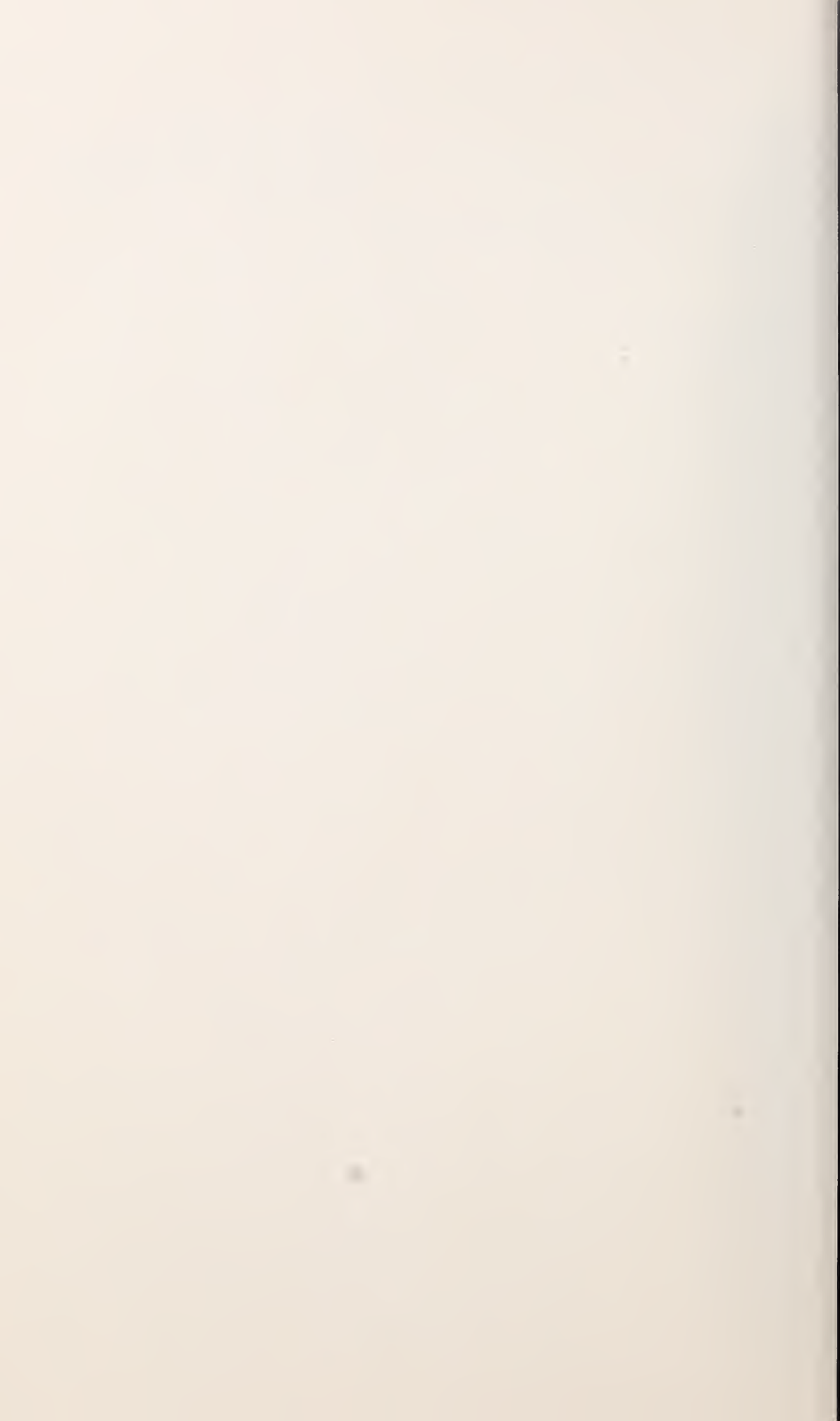
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